

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

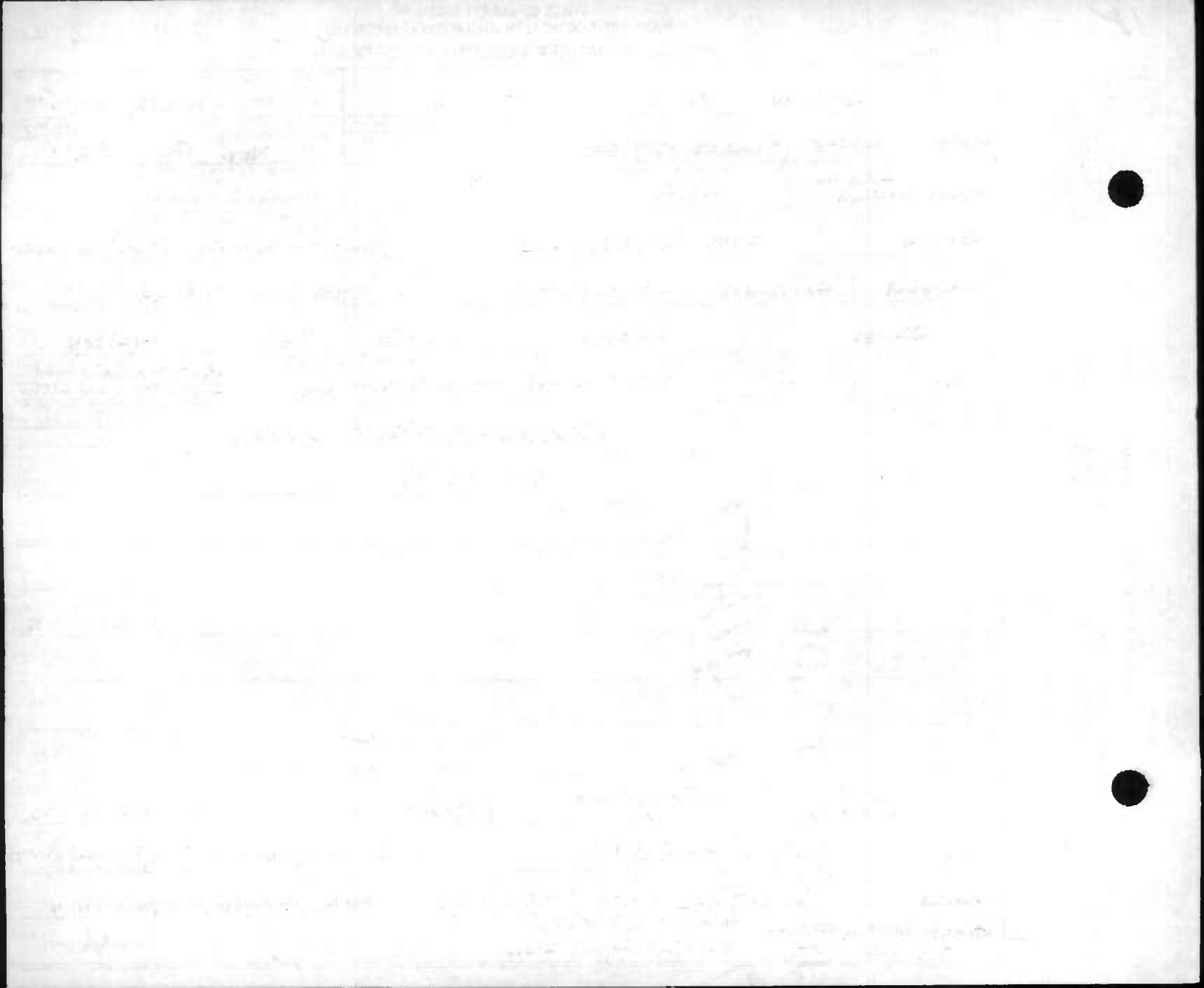
BP
DHMH - 17
(V A 15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Woodrow Wilson Adams			2a. DATE KNOWN OF DEATH MONTH DAY YEAR Nov. 12, 1982			2b. HOUR 6 ⁰⁰ M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 22, 1917	6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Nov. 12, 1982	7d. HOUR 9 ⁰⁰ M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ashe Co. North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2908 Mountain Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder - Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Container Repair
13a. STATE Maryland			13b. COUNTY Harford Co.	13c. CITY OR TOWN Joppa (21085)	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2908 Mountain Road		
14. FATHER'S NAME FIRST MIDDLE LAST James Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Bell Walton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT (WIFE) 676-9387 ADDRESS Mrs. Lillian V. Adams 2908 Mountain Road Joppa, Maryland 21085				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) ASLUD. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Luis E. RENJEL, M.D.				ADDRESS 464 Alliance St., Haute de Grace, Maryland 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Joseph William Foster				25a. DATE REC'D. BY REGISTRAR NOV 17 1982		REGISTRAR'S SIGNATURE John J. Gough		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 2 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY M. BONER				2a. DATE OF DEATH MONTH DAY YEAR NOV. 30 82		2b. HOUR 12 45 PM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 28 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN North East	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Ahearn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Phelan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 262-20-7688		17. INFORMANT ADDRESS Mary L. Limer Warrenton N.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) ASD DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-23, 19 82, to 11-30, 19 82, that (I) (we) lost saw the deceased alive on 11-30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE JOHN D. YUN M.D.				22c. ADDRESS HARFORD		22d. DATE SIGNED 11/30/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN				22f. ADDRESS HARFORD			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE 12-4-82		23c. NAME OF CEMETERY OR CREMATORY St. Mary Anne's		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.	
24. FUNERAL DIRECTOR NAME Paul R. Branch				25a. DATE REC'D. BY REGISTRAR DEC 9 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

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100 + 100 = 200

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 2 9

REG. NO.

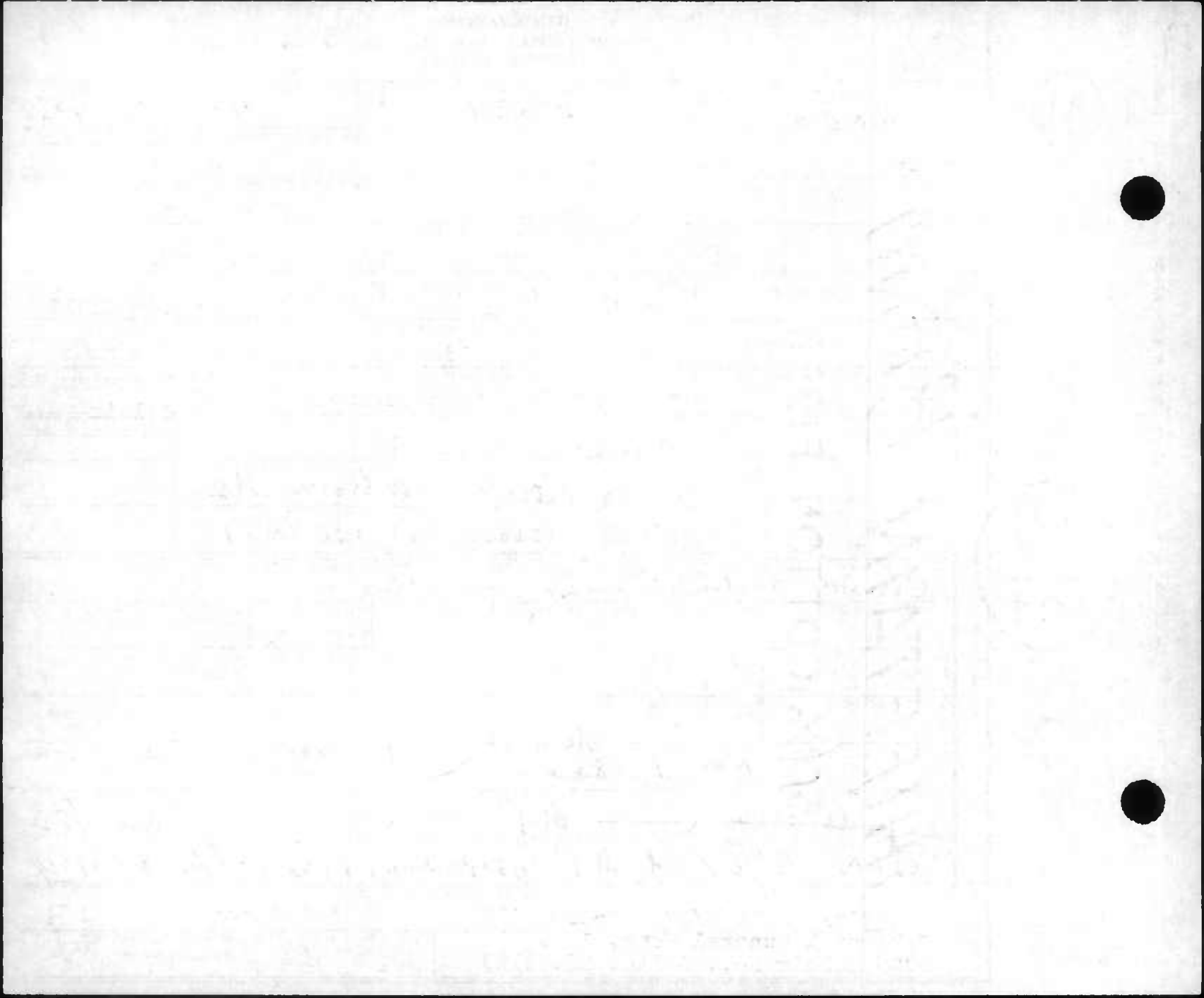
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NORMA E. BOWEN		2a. DATE OF DEATH MONTH DAY YEAR 11-3-82		2b. HOUR 4:50 A.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Dec. 10 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Switch Board Operator -		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1615 Park Ave. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST John Norfolk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Shafer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-05-8084D		17. INFORMANT ADDRESS 510 Westview Rd. Bel Air Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis, generalized					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic obstructive pulmonary disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 16 , 19 79 , to Nov. 3 , 19 82 , that (I) (we) last saw the deceased alive on Nov. 1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (we) view the body after death.					
22b. SIGNATURE Bendley		DEGREE M.D.		22c. DATE SIGNED Nov. 3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEN OTEY ZA, M.D.		22e. ADDRESS 1131 Baltimore Pike, Bel Air, Md. 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.					
24. FUNERAL DIRECTOR NAME Genimunek Funeral Home, Inc.		ADDRESS 9705 Belair Rd., Balto. Md. 21236		25a. DATE REC'D. BY REGISTRAR NOV 5 1982	
25b. REGISTRAR'S SIGNATURE John L. Calver					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 9 4 3 0						
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) OMA Iatho BRAGG					2a. DATE OF DEATH MONTH DAY YEAR 11 03 82				2b. HOUR 9:45 A.M.		
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 01 82		6. AGE (IN YEARS LAST BIRTHDAY) 100		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina USA		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1829 Churchville Road			
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Hall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wyatt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT (NAME, ADDRESS, ADDRESS) Mrs. Anna Dickey 801 Coconut Court Bel Air, Md. 21014							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> 19 <u>82</u> to <u>Oct</u> 19 <u>82</u> that (I) (we) lost the deceased alive on <u>10/29</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Andrew Nowakowski</u>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/3/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Nowakowski, M.D.				22e. ADDRESS 125 North Main Street, Bel Air, Maryland 21014							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 5, 1982		23c. NAME OF CEMETERY OR CREMATORY Smith Chapel Meth. Ch. Con.		23d. LOCATION CITY OR TOWN COUNTY STATE Churchville, Harford Co., Maryland 21014					
24. FUNERAL DIRECTOR Joseph William Foster <u>Joseph William Foster</u>				25a. DATE REC'D. BY REGISTRAR NOV 8 1982				25b. REGISTRAR'S SIGNATURE <u>Angela Smith</u>			

2015-01-01

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN C. BRAZIL			2a. DATE OF DEATH MONTH DAY YEAR 11 1 82		2b. HOUR MIN. 6 08 A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR June 11 1903		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 7 9		
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST William Murphy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hoffmeyer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-50-1528		17. INFORMANT ADDRESS John Brazil (son) 9015 Tammy Rd. 36		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Aortic DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Epilepsy - old CVA -						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-30-82 to 11-1-82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-1-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE J. L. Pirovich		DEGREE MD		22c. DATE SIGNED 11/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/82		23c. NAME OF CEMETERY OR CREMATORY New Csthdral		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. ADDRESS 9705 Belair Road, Balto. Md. 21236				
25. DATE REC'D BY REGISTRAR NOV 3 1982		26. REGISTRAR'S SIGNATURE John J. Gair				

Let G be a group and H a subgroup of G . Then H is a normal subgroup of G if and only if $gHg^{-1} = H$ for all $g \in G$. This is equivalent to saying that H is invariant under conjugation by elements of G .

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 3 2

1- FOR
STATE
REGISTRAR

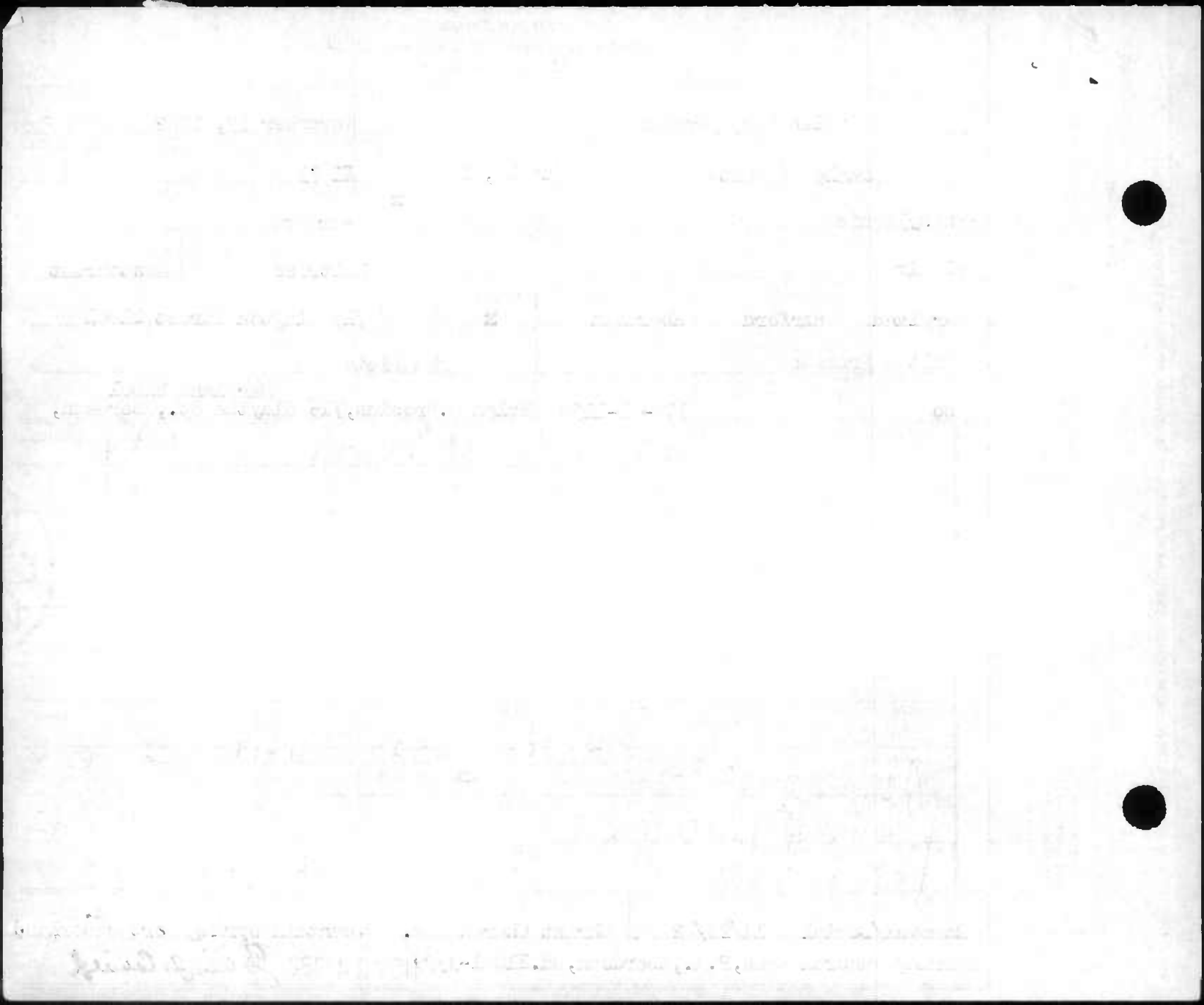
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Mary Brosius			2a. DATE OF DEATH MONTH DAY YEAR November 19, 1982		2b. HOUR 7:30 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 18, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 73 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BACC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Milton Brosius			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Dietz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 178-01-1139		17. INFORMANT ADDRESS Maryland 21001 Ralph M. Brosius, 715 Clayton St., Aberdeen,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3352 Amyotrophic lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-20-82 to 11-19-82 , that (I) (we) lost the deceased on 11-19-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we did not view the body after death).								
22b. SIGNATURE Peter P. Rodman, M.D.				DEGREE		22c. DATE SIGNED 11-19-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
Peter P. Rodman, M.D.				8 Low St. Aberdeen, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial		23b. DATE 11/22/82		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fountain Spring Schuylkill, Pa.		
24. FUNERAL DIRECTOR Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399				25a. DATE REC'D. BY REGISTRAR NOV 24 1982				
				25b. REGISTRAR'S SIGNATURE John J. Carver				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 3 3

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leo BROWN			2a. DATE OF DEATH MONTH DAY YEAR November 27, 1982			2b. HOUR 2:34 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH DAY MONTH YEAR 14-11-1913		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Retired		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS 70 Wilbur Road		13c. CITY OR TOWN Harford	
14. FATHER'S NAME FIRST MIDDLE LAST Lukashenko		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lukashenko		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 213-16-3116		17. INFORMANT ADDRESS Florence Wilbur Brown Lukashenko, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction, Inferior DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 90 min									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Calcification of gastric cardia									
19a. DATE OF OPERATION 11/10/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of gastric cardia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-8, 1982, to November 27, 1982, that (I) (we) last saw the deceased alive on November 27, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE AWERIGOLEIT		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/27/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AWERIGOLEIT		22e. ADDRESS HARRIS DELZARE 21078							
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 11/30/1982		23c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.			
24. FUNERAL DIRECTOR NAME Loring Funeral Home - Harford, Md		25. DATE REC'D. BY REGISTRAR DEC 6 1982		REGISTRAR'S SIGNATURE John J. Canine					

MEDICAL CERTIFICATION

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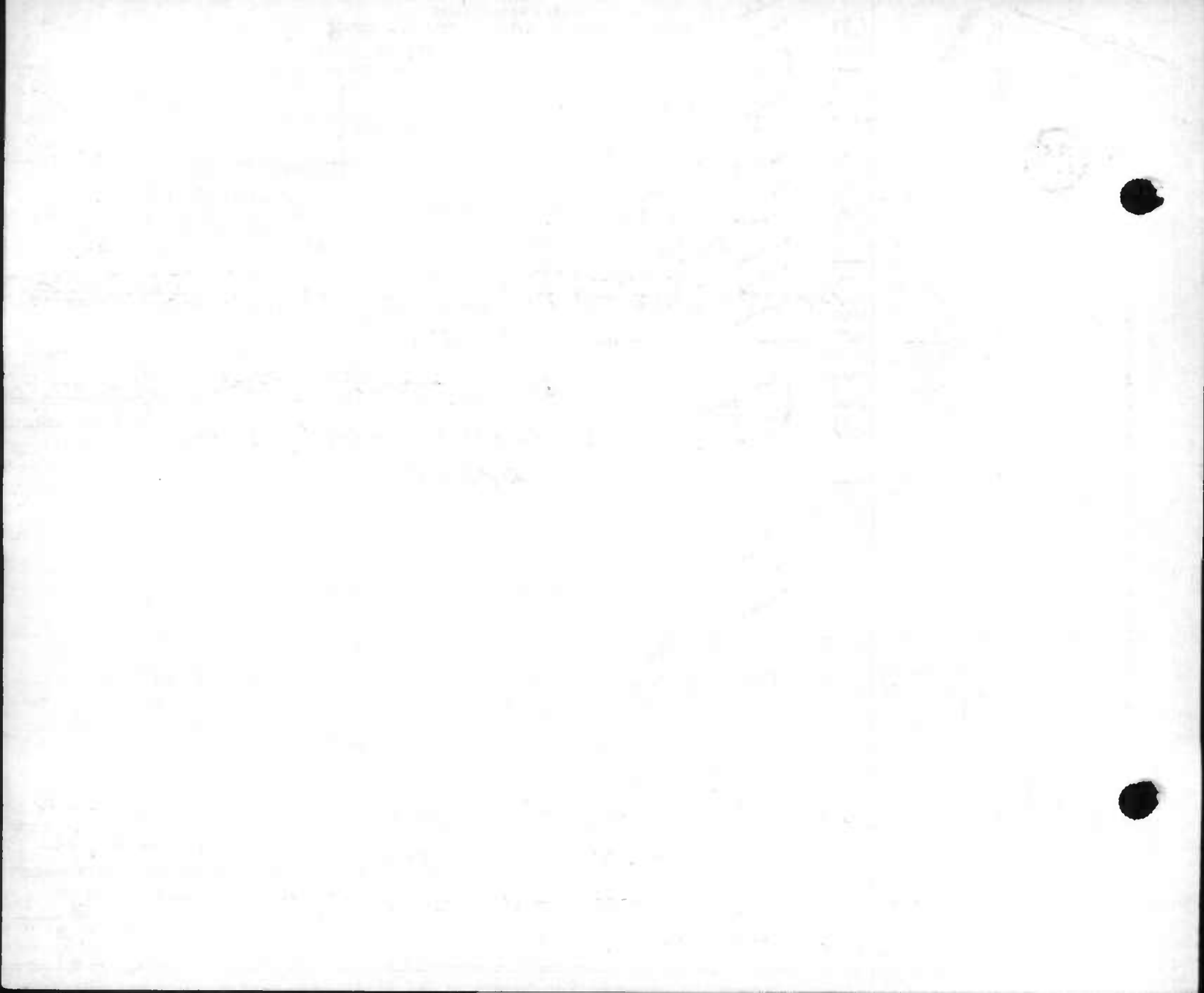
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

OHMH-17
(VR A15 ME (5))
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 29434	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAY WARREN BURCHAM										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 11 6 1982	
3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 12 19 19 62 YRS.										2b. HOUR 330 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 6 1982	
10. CITY OR TOWN OF DEATH Fallston 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Arlington General										2d. HOUR 33 M	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Harford 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										2e. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
14. FATHER'S NAME FIRST MIDDLE LAST James Avery Burcham										12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Farmer 12c. KIND OF BUSINESS OR INDUSTRY Agric.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. WWII 215-12-8649 17. INFORMANT ADDRESS Mrs. Catherine S. Burcham, Forest Hill Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Luis E. Renjal M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-6-82											
EXAMINER'S NAME (TYPE OR PRINT) Luis E Renjal ADDRESS 464 Allman St Hd de Jc											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Nov. 9, 1982 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.											
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 ADDRESS 25a. DATE REC'D. BY REGISTRAR NOV 8 1982 25b. REGISTRAR'S SIGNATURE											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

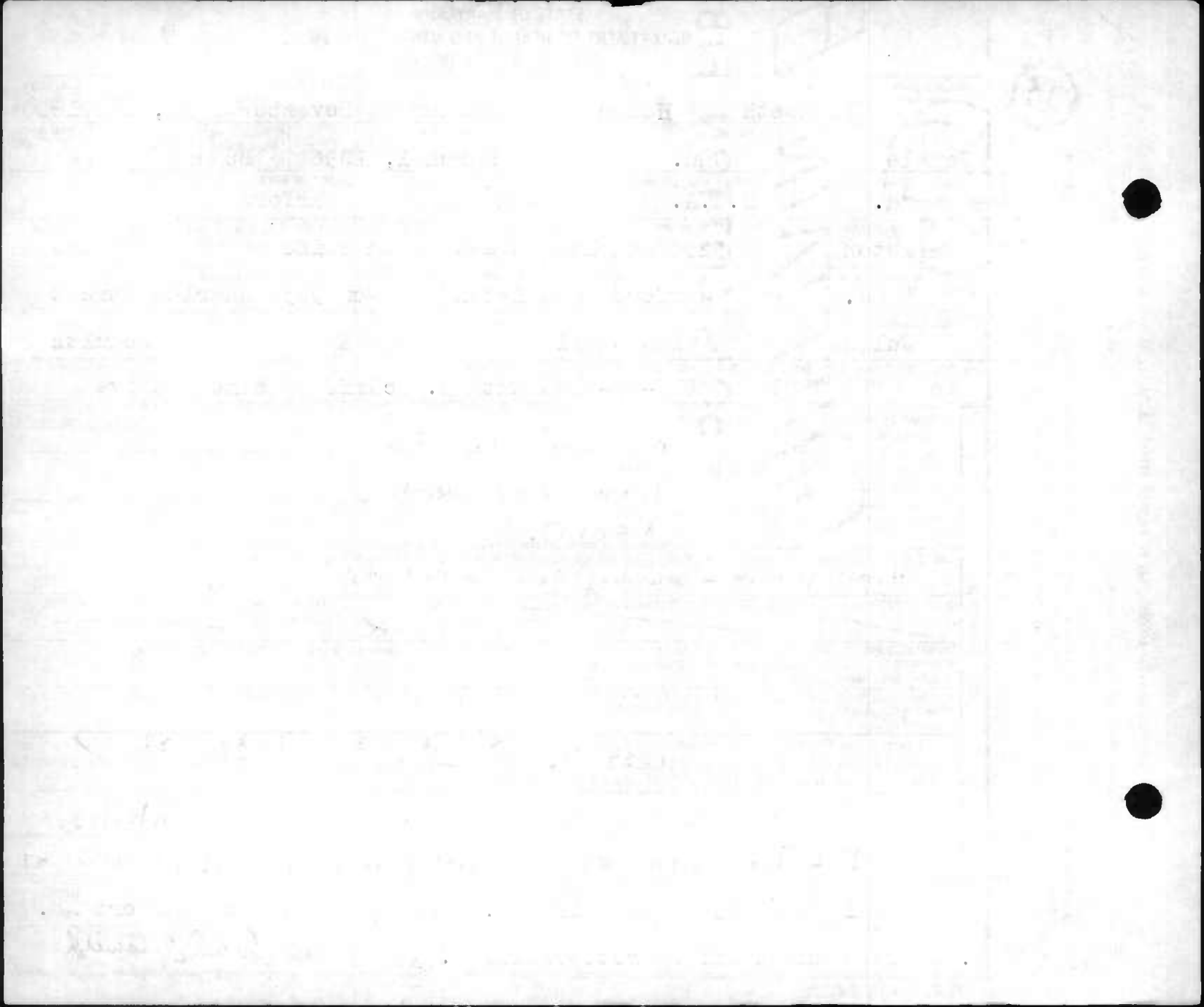
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Elizabeth Helen Busler			2a. DATE OF DEATH Month November Day 29 Year 1982		2b. HOUR 1000 M
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH March 1, 1896		6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3234 Charles Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3234 Charles Street	
14. FATHER'S NAME First Middle Last Julius Winskowski		15. MOTHER'S MAIDEN NAME First Middle Last Wanda Schultz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 213-48-9106		17. INFORMANT Address Ruth B. Scarff same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease. DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypothyroidism - Secondary Anemia - Arthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 18, 1978 , to 11-29, 1982 , that we (we) last saw the deceased alive on 11-29 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.L. Pirovolidis MD		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/30/82.	
22d. PHYSICIAN'S NAME (Type) D.L. PIROVOLIDIS MD.		22e. ADDRESS 1716 HARFORD Rd. FALLSTON, Md. 21047			
23a. BURIAL CREMATION, REMOVED Burial	23b. DATE 12/2/1982	23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.	
24. FUNERAL DIRECTOR M. Gladden Kurtz III Jarrettsville, Md		ADDRESS		25a. REC'D BY REGISTRAR DEC 2 1982	25b. REGISTRAR'S SIGNATURE John J. Loush



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 3 6			
1. FOR STATE REGISTRAR (Blair Norman Carper)				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Blair Norman Carper				2a. DATE OF DEATH MONTH DAY YEAR Nov. 5 1982		2b. HOUR 3:15 P.M.	
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 28 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston (21047)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1702 Fallston Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinest		12b. KIND OF BUSINESS OR INDUSTRY Radio	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford Co. 13c. CITY OR TOWN Fallston (21047)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1702 Fallston Road	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Allen Carper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola White			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 174-16-9301		17. INFORMANT (NAME) 877-7095 ADDRESS Mrs. Iva P. Carper 1702 Fallston Road Fallston, Maryland 21047			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes & stasis ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Amputation legs bilateral</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION Nov. 5 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED legs bilateral		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5 1982</u> to <u>Nov. 5 1982</u> , that (I) (we) last saw the deceased alive on <u>Nov. 5 1982</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William A. Tyson M.D.				DEGREE M.D.		22c. DATE SIGNED 11-5-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Tyson				22e. ADDRESS Box 158 Kingsville Md. 21087			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Churchville Harford Co. Maryland 21028	
24. FUNERAL DIRECTOR Joseph William Foster Bel Air, Maryland 21014				25a. DATE REC'D. BY REGISTRAR NOV 8 1982 25b. REGISTRAR'S SIGNATURE John J. Carver			

1914 Nov 28

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 3 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Leonard M. Carter Jr.</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>11 10 82</i>			
3. SEX <i>Male</i>				4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 12- 1908</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Co. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		2b. HOUR <i>15</i> MIN. <i>2 P.M.</i>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford Co. Md.</i>			
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Set-up & Ass. Man</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Koppers Co.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Kingsville</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Leonard Carter</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Golda Emma Mast</i> Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-09-9888</i>		17. INFORMANT ADDRESS <i>11901 Stoney Batter</i> <i>Mrs. Gladys R. Carter, Kingsville, Md. 21087</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4100 Cardiac arrest</i> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <i>Massive myocardial inf</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Atherosclerosis</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1982</i> to <i>Sept 1982</i> , that (I) (we) lost saw the deceased alive on <i>11-10-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M.D.</i> DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-10-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>V. S. NAIR M.D.</i>				22e. ADDRESS <i>1716 Haged Road - Fallston MD 21047</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-13-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fork U. Meth. Ch. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Fork Baltimore Md.</i>	
24. FUNERAL DIRECTOR NAME <i>E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 15 1982</i>			
				25b. REGISTRAR'S SIGNATURE <i>John J. Carter</i>			

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

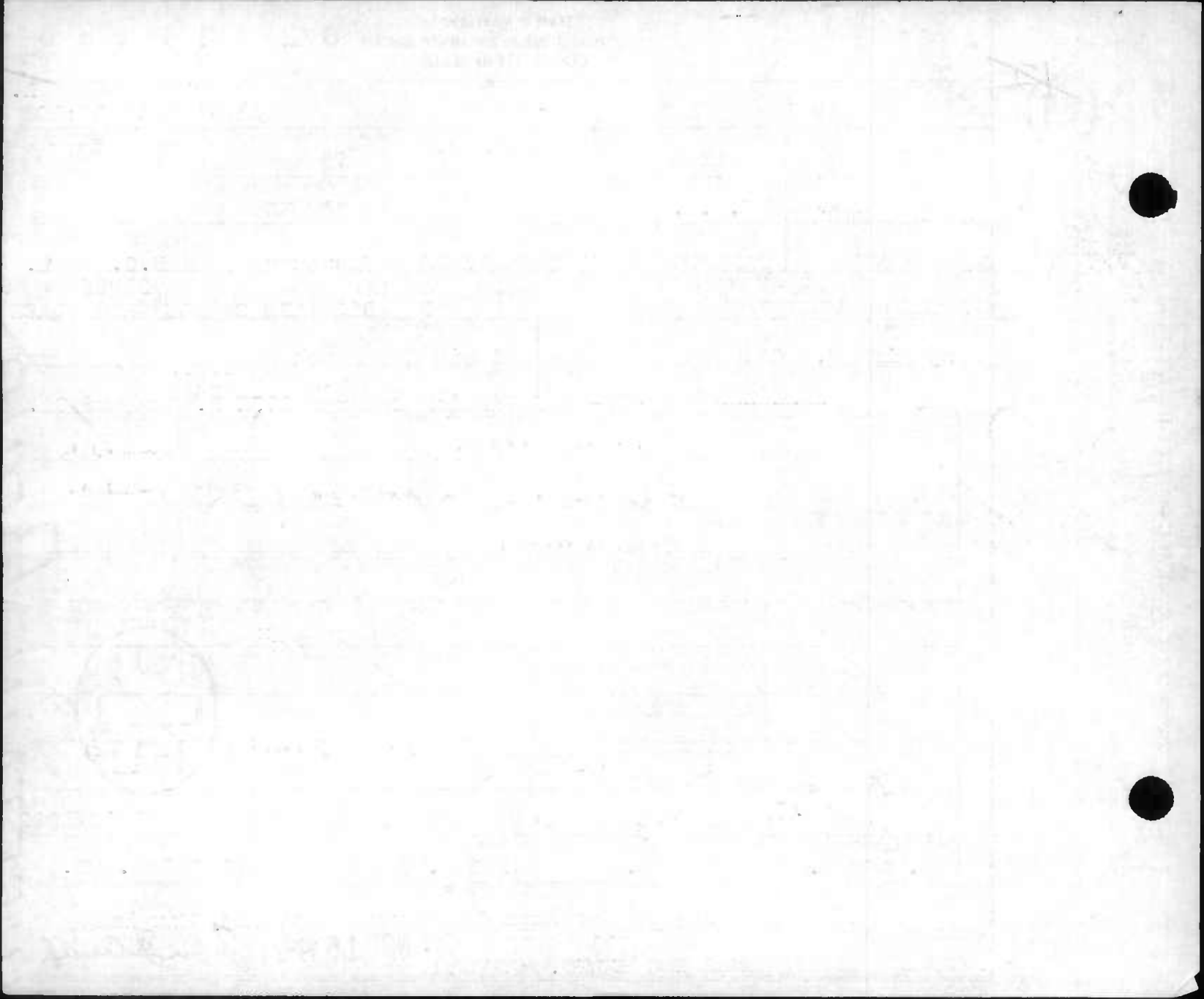
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 3 8

1 - FOR STATE REGISTRAR		REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MABEL	MIDDLE LEE	MONTH 11	DAY 11
LAST COCHRANE		YEAR 1982	
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))
		MONTH 4	DAY 21
		YEAR 1903	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina	U.S.A.		HARFORD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
FALLSTON	FALLSTON GENERAL HOSPITAL	Secretary	U.S. Govt.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MARYLAND	HARFORD	JOPPA	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST Benjamin	FIRST Minnie Lee	21085	
MIDDLE F.	MIDDLE Leach	392 APT C4 ELSWORTH PLACE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	218-09-2805	William Cochran	21231
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>immediate</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>11/2</u> 19 <u>82</u> to <u>present</u> 19 <u>82</u> , that (we) lost saw the deceased alive on <u>11/2</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Lee E. Gresser</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/12/1982
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LEE E. GRESSER MD.	22e. ADDRESS 4502 N. CHARLES STREET BALTO. MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov 15, 82	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION CITY OR TOWN Baltimore Maryland
24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOMES INC BALTO. MARYLAND	ADDRESS 7110 BELAIR RD.	25a. DATE OF REGISTRATION NOV 15 1982	25b. REGISTRAR'S SIGNATURE <u>John J. Connelley</u>



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 3 9

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BESSIE JEANETTE CRAMER			2a. DATE OF DEATH MONTH DAY YEAR 11 15 82		2b. HOUR 1:50 A.M.
3. SEX FEMALE	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD Co., MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Harford		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward D. Lowry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Cromleigh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212 18 0867A		17. INFORMANT ADDRESS Mr. Albert G. Cramer 638 Regester Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease yr 5 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 9/14 , 19 82 , to 10-27 , 19 82 , that (ii) (we) last saw the deceased alive on 10/27/82 , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David Goldsher		DEGREE MD		22c. DATE SIGNED 11-15-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Goldsher, M. D.		22e. ADDRESS Good Samaritan Hospital Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/18/82		23c. NAME OF CEMETERY OR CREMATORY Utica Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Co., Md.		25a. DATE REC'D. BY REGISTRAR NOV 19 1982			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.		25b. REGISTRAR'S SIGNATURE John J. Carver			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner will be notified at once.

8-10-1944
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

TO: Mr. J. H. ...
FROM: Mr. ...

SUBJECT: ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 2 9 4 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lawrence Louis Crovo			2a. DATE OF DEATH MONTH DAY YEAR November 24, 1982		2b. HOUR 2:30 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 23, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COPPER SMITH	12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY HARFORD 13c. CITY OR TOWN BEL AIR			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21014 213 CROCKER DR. APT 3	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS - CROVO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA CUNEO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 217-09-2980		17. INFORMANT ADDRESS MRS ANNA MARIE CROVO Same As #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) STROKE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS (c) DUE TO OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-21 , 19 82 , to 11-24 , 19 82 , that (I) (we) lost saw the deceased alive on 11-24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dante M. Monakil		DEGREE		22c. DATE SIGNED 11/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE M. MONAKIL		22e. ADDRESS 622 S. Union Ave. Hartford, Md.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 24 NOV 82		23c. NAME OF CEMETERY OR CREMATORY CRATIN & FARRIS	
23d. LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER PA		24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME, HAVRE DE GRACE, MD			
25a. DATE REC'D. BY REGISTRAR NOV 29 1982		REGISTRAR'S SIGNATURE John J. Carver			

(10)

NAME	GRADE	DATE	REMARKS
WILLIAM	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School
JOHN	MAJOR	1954	Harvard Univ. Med. School



RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE RUTH LAST CUNNINGHAM <i>Rxxxxx xxxx Cunningham</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 20 1982</i>		2b. HOUR <i>10:45 P M</i>					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 14, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.				
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE ADDRESS) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Darlington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 937 Priestford Road					
14. FATHER'S NAME FIRST Lonnie MIDDLE Baxter LAST Crouse			15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE Ellen LAST Toliver				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-46-6382	
17. INFORMANT ADDRESS Bel Air, Md. 21014 Ellsworth L. Cunningham, 21 Lake Drive										

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>1543</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Squamous cell carcinoma of anus with</i> (c) <i>visual and bone metastasis.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-8</i> , 19 <i>82</i> , to <i>11-20</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>11-20</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Nov 20 82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>IAN D. SOMERVILLE</i>				22e. ADDRESS <i>400 LEWIS ST HARRE DE GRACE MD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 24, 1982		23c. NAME OF CEMETERY OR CREMATORY Deer Creek U.M. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 23 1982			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 only. Page 2 only. Page 3 only. Page 4 only. Page 5 only. Page 6 only. Page 7 only. Page 8 only. Page 9 only. Page 10 only. Page 11 only. Page 12 only. Page 13 only. Page 14 only. Page 15 only. Page 16 only. Page 17 only. Page 18 only. Page 19 only. Page 20 only. Page 21 only. Page 22 only. Page 23 only. Page 24 only. Page 25 only. Page 26 only. Page 27 only. Page 28 only. Page 29 only. Page 30 only. Page 31 only. Page 32 only. Page 33 only. Page 34 only. Page 35 only. Page 36 only. Page 37 only. Page 38 only. Page 39 only. Page 40 only. Page 41 only. Page 42 only. Page 43 only. Page 44 only. Page 45 only. Page 46 only. Page 47 only. Page 48 only. Page 49 only. Page 50 only. Page 51 only. Page 52 only. Page 53 only. Page 54 only. Page 55 only. Page 56 only. Page 57 only. Page 58 only. Page 59 only. Page 60 only. Page 61 only. Page 62 only. Page 63 only. Page 64 only. Page 65 only. Page 66 only. Page 67 only. Page 68 only. Page 69 only. Page 70 only. Page 71 only. Page 72 only. Page 73 only. Page 74 only. Page 75 only. Page 76 only. Page 77 only. Page 78 only. Page 79 only. Page 80 only. Page 81 only. Page 82 only. Page 83 only. Page 84 only. Page 85 only. Page 86 only. Page 87 only. Page 88 only. Page 89 only. Page 90 only. Page 91 only. Page 92 only. Page 93 only. Page 94 only. Page 95 only. Page 96 only. Page 97 only. Page 98 only. Page 99 only. Page 100 only.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William J. Dodsworth			2a. DATE OF DEATH MONTH DAY YEAR November 11, 1982		2b. HOUR 2:15 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 10 1927	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH HARFORD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance/Auto		12b. KIND OF BUSINESS OR INDUSTRY Proving Ground
13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Port Deposit	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Dodsworth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cosby Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 216-20-8797		17. INFORMANT ADDRESS 33 Maple Hill Drive Port Deposit, Md. 21904	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

4149

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to November 11, 1982, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Dante Monakul		22c. DATE SIGNED 11/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONAKUL, DANTE		22e. ADDRESS Harford, Md 2178	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 15, 1982	23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.
24. FUNERAL DIRECTOR NAME A. Patterson & Son		25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE NOV 19 1982 John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 3

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence ENGLAND</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>November 16 1982</i>		2b. HOUR <i>3:54 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 27 1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>83</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>A. Fred T. CROTHERS</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie DOYLE</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		17. INFORMANT ADDRESS <i>Lillie ENGLAND (SAME)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <i>4019 IMMEDIATE CAUSE (a) Cardiac arrest</i> DUE TO OR AS A CONSEQUENCE OF (b) <i>Hypertension and atherosclerosis</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>Cardiac arrhythmia & congestive heart failure</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Brian T. Yeo</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>11/16/82</i>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Brian T. Yeo, M.D.</i>		22g. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>11-19-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROSEBANK Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>CHALVERT Cecil Md.</i>	
24. FUNERAL DIRECTOR NAME <i>R.T. FOARD FUNERAL HOME</i>		24b. ADDRESS <i>Rising Sun Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 22 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

MEDICAL CERTIFICATION

BP _____



NO	—	195-25-250 Willie Eugene	(same)
W/PO	T	COCHRAE	Willie
W/PO	CECIL	BRIDGES	Wm
W/PO	X	195	Walter Eugene
W/PO		W/PO	W/PO
W/PO	U.S.A.	X	
W/PO	WHITE	2	27 1000
		83	

RT Ford Funeral Home
11-19-82
Resident Company Calvert Cecil W/PO
195-25-250 Willie Eugene

COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John RIDGELY Fisher			2a. DATE OF DEATH MONTH DAY YEAR 11 7 82			2b. HOUR 10⁵⁰ AM	
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 26 02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) RET. KOPPERS Co.	
12b. KIND OF BUSINESS OR INDUSTRY MFG.							
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN FALLSTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2307 Harmony Terrace							
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. FISHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH RIDGELY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-16-6520		17. INFORMANT (NEPHEW) ALVIN M. GILL		ADDRESS SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 11/6			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/6 82			
22a. I certify that (I) (this hospital) attended the deceased from 11/7 19 82 , to 11/6 19 82 , that (I) (we) last saw the deceased alive on 11/7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Linda Feltch		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA FELTCH		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/9/82		23c. NAME OF CEMETERY OR CREMATORY CHRISTEPI SCOPAL CHURCH FOREST HILL		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD.	
24. FUNERAL DIRECTOR NAME E BARNES Fleming		ADDRESS Baltimore		25a. DATE REC'D. BY REGISTRAR NOV 10 1982		25b. REGISTRAR'S SIGNATURE James J. Carver	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

John RIDGELY Fisher

80

to be

WHITE

HARFORD

U.S.A.

MARKING

THURSDAY (October 1944) 1944

MA HARFORD (1944) ✓ 1944

William H. Fisher (1944) RIDGELY

NO ——— 1944 (1944) 1944

20%

Journal 11/12 CHRISTIANITY AND THE FUTURE OF THE WORLD
1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 5

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl William Fowler		2a. DATE OF DEATH MONTH DAY YEAR November 26, 1982		2b. HOUR 5:10 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Sawmill	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Dewey Franklin Fowler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Mae Hurley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII			
16b. SOCIAL SECURITY NO. 244-22-4490		17. INFORMANT ADDRESS Mrs. Doris R. Fowler, Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Undifferentiated carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1629</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-25</u> 19 <u>82</u> , to <u>11-26</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11-26</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ramiro Lindado</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-27-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMIRO R LINDADO		22e. ADDRESS Harford Memorial Hosp - Harford					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Nov. 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Reins-Sturdivant FH		23d. LOCATION CITY OR TOWN COUNTY STATE Jefferson Ashe N.C.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 29 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. IF THE DEATH IS REPORTED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Charles Anthony Franklin			MONTH DAY YEAR 11 24 1982			8:14 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
MALE	WHITE	JAN 14 1917	65 YRS.	MONTHS DAYS	HOURS MIN.	11 24 1982 8 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
ORANGE NJ		USA		NEVER MARRIED WIDOWED DIVORCED		HARFORD MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS
Fallston		Fallston General Hospital				CHIEF LOAN OFFICER		NABARD Hood PRESERVATION
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
NJ		ESSEX	ORANGE	YES NO	352 CENTRAL AVENUE			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST ANTONIO FRANKLIN			FIRST MIDDLE LAST MARY FRANKO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT (WIFE) ADDRESS		
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII NAVY RES.			455-18-8585			ELEANOR FRANKLIN Same AS #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
4140 IMMEDIATE CAUSE (a) CORONARY Heart Disease								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) ASKED								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?
								YES NO
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED			
			HOUR A.M. MONTH DAY YEAR P.M. 19		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
					CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Luis E. Renteria			M.D. Deputy			11-25-82		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Luis E. Renteria MD			464 Alliance St			Havre de Grace		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		11-29-82		ST. JOHNS		CITY OR TOWN COUNTY STATE ORANGE ESSEX NJ		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS E. BARNES Fleming Funeral Service Bearse, Md			NOV 30 1982			John J. Lohr		

1944

(11)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 1

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARJORIE L. GERLINGER			2a. DATE OF DEATH MONTH DAY YEAR November 5, 1982		2b. HOUR 1:05 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 12, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Leftwich		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Edwards		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-24-2113A	
17. INFORMANT George W. Tester		18. ADDRESS 4109 Webster Rd.		19. CITY OR TOWN Havre de Grace, MD		20. STATE MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 1519 DUE TO, OR AS A CONSEQUENCE OF (b) DISEASE CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins. WELLS.	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-4 , 19 82 , to 11-5 , 19 82 , that (I) (we) last saw the deceased alive on 11-5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benny A. Wahlen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-5-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY A. WOHLE M.D.		22e. ADDRESS 131 S. UNION AVENUE		CITY OR TOWN HARVRE DE GRACE		STATE MARYLAND 21078	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Highland Presby. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Street Harford MD	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A.		ADDRESS 333 S. Parke Aberdeen MD		25a. DATE REC'D BY REGISTRAR NOV 15 1982		25b. REGISTRAR'S SIGNATURE John J. Smith	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 4 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Katherine Mary Gillen			2a. DATE OF DEATH MONTH DAY YEAR 11-19-82		2b. HOUR 1:28pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08 18 01		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md		13b. COUNTY Harford		13c. STREET ADDRESS 202 Idlewild Street	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J Sullivan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie -- HEALY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 060-20-7063		17. INFORMANT (Relationship) ADDRESS (Daughter) 879-0954 Mrs. Kathleen G. Richards BEL Air Maryland 21014	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

4413

IMMEDIATE CAUSE (a) **Ruptured abdominal aortic aneurysm**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION Nov 19 '82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aneurysm.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 1982 , to Nov 19 1982 , that (I) (we) lost saw the deceased while in above; (I) (we) did not view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED Nov 19 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IAN D. SUMMERVILLE		22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE Nov 19, 1982	23c. NAME OF CEMETERY OR CREMATORY John A. Wallace III Calvary Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE New York, Queens Co., New York
23e. DATE REC'D. BY REGISTRAR NOV 22 1982		23f. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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brod-woll

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1212

Fallston General Hospital

File 10103

304 I 46 m 14 Street

24 Feb 1963

607

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

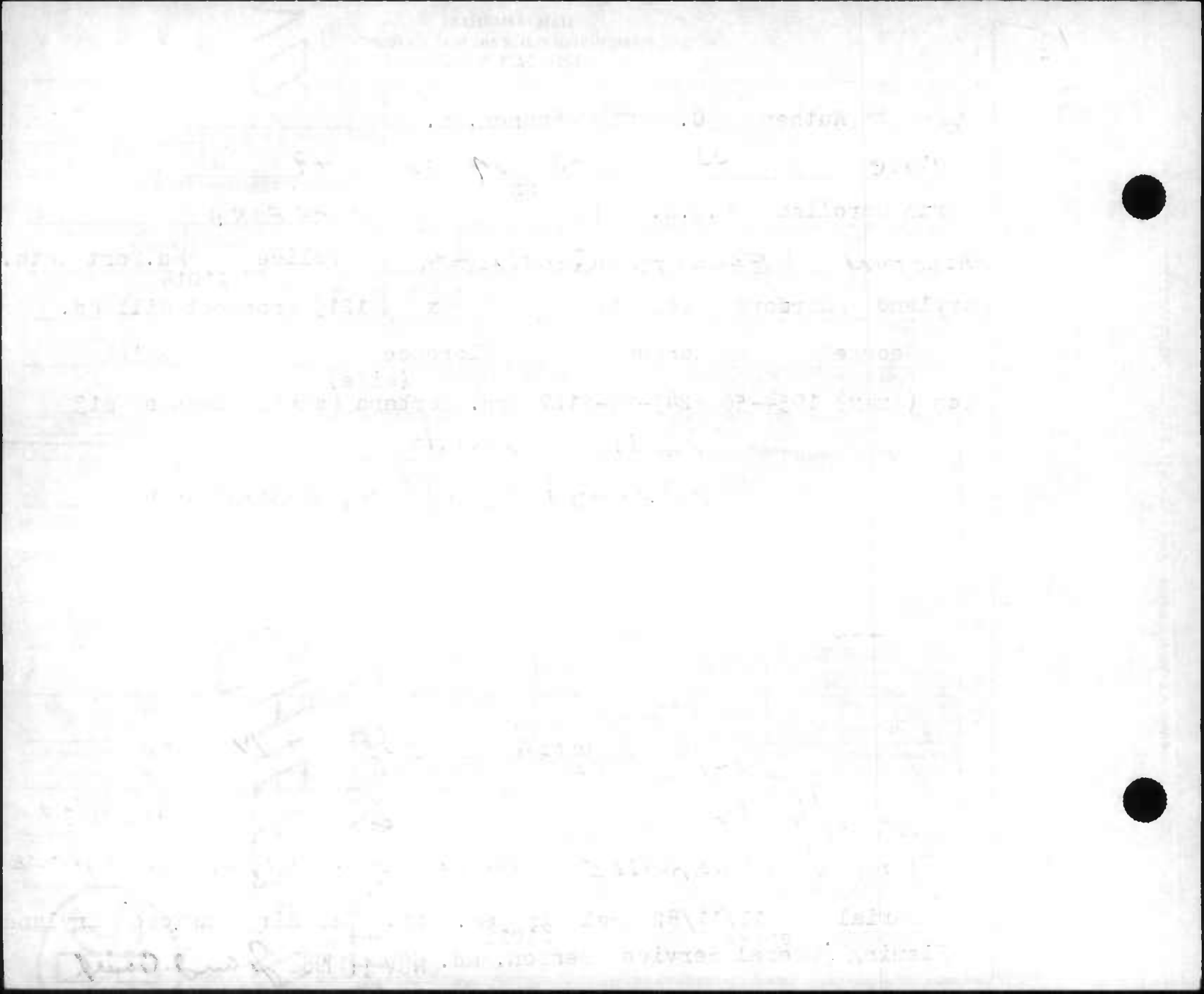
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 4 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Author C. Hannon, Sr.				2a. DATE OF DEATH MONTH DAY YEAR 11 7 82		2b. HOUR 3 P M	
3. SEX male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 03 07 33		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 49	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police		12b. KIND OF BUSINESS OR INDUSTRY Md. Port Auth.	
13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Bel Air				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1215 Prospect Mill Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST George Hannon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Swink			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (Army)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954-56		17. INFORMANT (Wife) ADDRESS Mrs. Barbara Hannon Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced ca of lung-metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/27, 19 82, to 11/7, 19 82, that (I) (we) last saw the deceased alive on 11/6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE —		22c. DATE SIGNED Nov 7 '82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IAN D. SOMERVILLE				22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/11/82		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland	
24. FUNERAL DIRECTOR E. Barnes Preming Funeral Service				25a. DATE REC'D. BY REGISTRAR 11/10/82 REGISTRAR'S SIGNATURE John J. Grier			

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

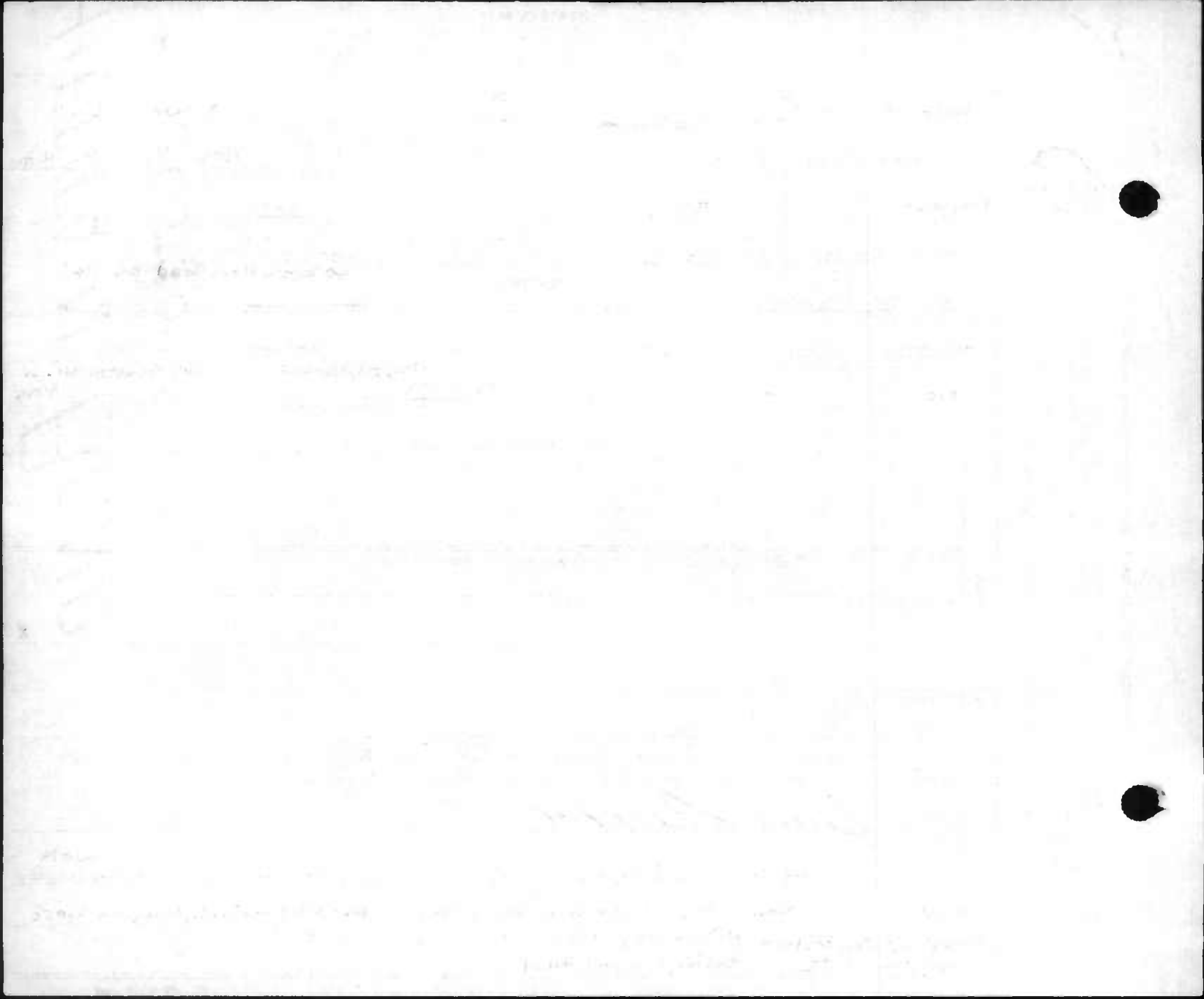
BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2 29450	
1. DECEASED NAME (TYPE OR PRINT) ① Katherine Virginia Harkins Burns		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Nov. 6, 1982	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 6 24	6. AGE (IN YEARS) (LAST BIRTHDAY) 58 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD
10. CITY OR TOWN OF DEATH Havre De Grace	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Trailer Pk. 16 Pine St. Swan Harbor Dell	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting Tech.	12b. KIND OF BUSINESS OR INDUSTRY APG
13a. STATE MD	13b. COUNTY Harford	13c. CITY OR TOWN Havre De Grace	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Millard Lee Harkins	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Poole	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
17. SOCIAL SECURITY NO. 219 18 0592		18. INFORMATION (daughter) 836-3818 ADDRESS 1401 Gunston Rd. Bel Air, MD 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASCVD (c) DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Luis E. Renjel		TITLE (SPECIFY) Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		DATE SIGNED 11-8-82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 11, 1982	23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co. Maryland 21050
24. FUNERAL DIRECTOR (SPECIFY) Joseph William Foster Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR NOV 12 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 5 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST PAUL MIDDLE DANIEL LAST HARRIS				2a. DATE OF DEATH MONTH DAY YEAR Nov. 26, 1982		2b. HOUR 5 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 6, 1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAURE de BRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trackman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Abingdon				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3215 Abingdon Road	
14. FATHER'S NAME FIRST MIDDLE LAST John Clayton Harris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Illie Washington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-09-7554		17. INFORMANT ADDRESS Richard L. Harris, Forest Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) dehydration (c) poor General condition PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 82 , to 11-26 , 19 82 , that (I) (we) lost saw the deceased alive on 11-26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. T. Lee				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. T. Lee				22e. ADDRESS Union Med. Ctr., Hdbg			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY John Wesley U.M. Cemetery, Abingdon Harford Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 29 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

2

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Handwritten text at the bottom of the page, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 5 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE HARRISON			2a. DATE OF DEATH MONTH DAY YEAR 11 21 82		2b. HOUR 12 35 AM						
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 08 07 96		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTH PLACE (CITY OR TOWN) N. VA.		7b. CITIZEN OF WHAT COUNTRY? US.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN BELAIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20 N. KELLY AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST William H. Kable				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Lee Massey				ADDRESS 20 N. Kelly Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) UNKNOWN MD		16b. SOCIAL SECURITY NO. 21352 9016		17. INFORMANT Mrs. Hannah L. Randall, Belair, Md. 21014							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive renal failure 1536 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma right colon DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c Congestive heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHERE: <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/1, 19 82, to 11/21, 19 82, that (I) (we) last saw the deceased alive on 11/20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Willard P. Amos		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amos		22e. ADDRESS 2404 Pleasantville Rd, Fallston, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-24-1982		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md.					
24. FUNERAL DIRECTOR NAME Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR NOV 24 1982		REGISTRAR'S SIGNATURE John J. Canish							

BP _____

OFFICE OF THE ATTORNEY GENERAL
STATE OF CALIFORNIA

3/10

William H. Harte
Rafael
Maurice
James
James H. Harte
30 E. Holly Ave.
San Jose, Calif. 95128

WILEY

20% COL

San Francisco
11-2-1982
San Francisco
San Francisco
San Francisco

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 5 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick K Louis Hiser				2a. DATE OF DEATH MONTH DAY YEAR November 12 1982		2b. HOUR 2:03 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR November 5, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Park Ranger		12b. KIND OF BUSINESS OR INDUSTRY State of Md.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Aberdeen				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 320 S. Parke St. Aberdeen, Md. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Hiser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Richards			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-18-0351		17. INFORMANT ADDRESS Mary W. Hiser 320 S. Parke St. Aberdeen, Md. 21001			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Extensive Myocardial Infarction</u> (c) <u>Arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes Mellitus</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> 19 <u>82</u> to <u>11/12</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante Monakil				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL				22e. ADDRESS 6725 Union Ave Havre de Grace Md 21001			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE November 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford MD.	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A. 333 S. Parke St. Aberdeen, Md.				25a. DATE REC'D. BY REGISTRAR NOV 26 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

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1001
March 27 1901

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clifford O'Neill Holland			2a. DATE OF DEATH MONTH DAY YEAR Nov. 10 82		2b. HOUR 8:45 AM
3. SEX MALE	4. RACE NEgro	5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARford MD.	
10. CITY OR TOWN OF DEATH HAVER de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY A. P.G.	
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYland	13b. COUNTY HARford	13c. CITY OR TOWN HAVER de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 626 Girard Street	
14. FATHER'S NAME FIRST MIDDLE LAST William T. Holland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES M. Preston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. 218-10-6363		17. INFORMANT ADDRESS Geneva C. Holland, Haled, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 82 , to 11-10 , 19 82 , that (I) (we) last saw the deceased alive on 11-10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dante Monakil		DEGREE MD		22c. DATE SIGNED 11/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONAKIL, DANTE		22e. ADDRESS 622 S. Union Ave. Haver de Grace, Md.			
23a. BURIAL CREMATION, REMOVAL	23b. DATE NOV. 13 1982	23c. NAME OF CEMETERY OR CREMATORY Beekley Cem. Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE DARLINGTON HARford MD.	
24. FUNERAL DIRECTOR John D. Bullock		ADDRESS 21078 MD.		25a. DATE REC'D. BY REGISTRAR NOV 23 1982	
				25b. REGISTRAR'S SIGNATURE John J. Gough	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



REPORT OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
JANUARY 1, 1902

ALBANY:
JANUARY 1, 1902

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 5 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lilyan A. Howard		2a. DATE OF DEATH MONTH DAY YEAR 11-12-82		2b. HOUR 1:55 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov 29 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY -
13a. STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN BelAir	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Bishop		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Rose A. (unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 266-27-7340	17. INFORMANT ADDRESS Bowling A. J. Howard (husband)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypovolemic Shock from 2502 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 Hours
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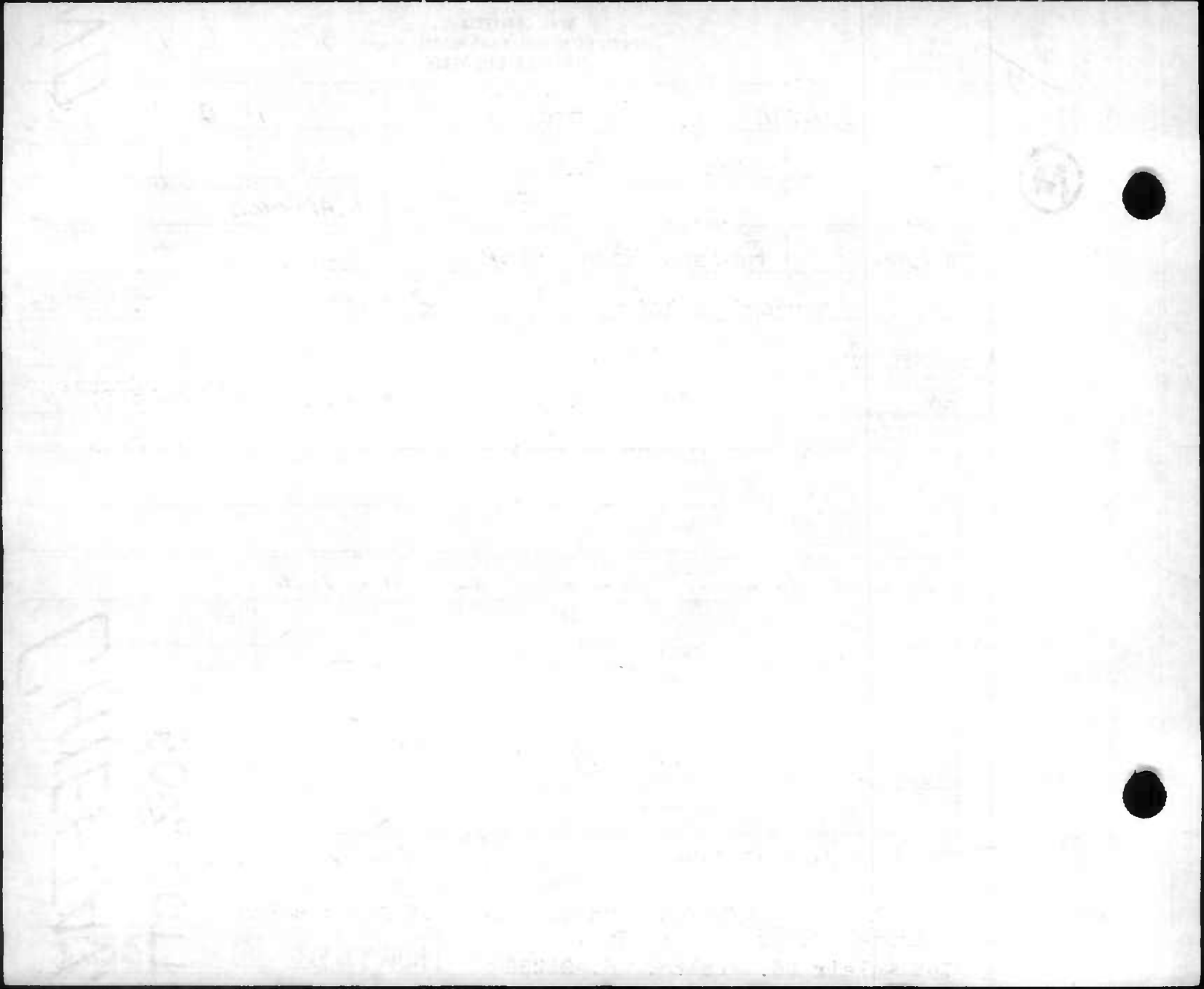
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Aspiration Pneumonia. Hemiplegia due to old stroke			
19a. DATE OF OPERATION 11/12/82	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aspiration Pneumonia	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Aspiration	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE Fallston Gen. Hospital	
22a. I certify that (I) (this hospital) attended the deceased from Nov 11, 1982 to Nov 12, 1982 , that (I) (we) last saw the deceased alive on Nov 12, 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE A. J. Sweetman	DEGREE Physician	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/12/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. SWEATMAN		22e. ADDRESS Fallston Gen. Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/15/82	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Balto.	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL HOME NAME ADDRESS Schumaker Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236		25a. DATE REC'D. BY REGISTRAR NOV 16 1982	25b. REGISTRAR'S SIGNATURE John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at ()



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, air removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 5 6

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Raymond Johnson			2a. DATE OF DEATH MONTH DAY YEAR November 16 1982		2b. HOUR 4:30 PM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 1, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland			13b. COUNTY Harford	13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Emory Elsworth Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Emma Pyle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-18-6440		17. INFORMANT ADDRESS R. Wilson Johnson Bel Air, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (c) Cerebrovascular insufficiency PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerosis cerebrovascular disease						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 P.M. 10 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (FARM, HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1115 Jarrettsville Road Jarrettsville Harford Md.		
22a. I certify that I (this hospital) attended the deceased from 11/13/82 to 11/16/82 that (I) (we) last saw the deceased alive on 11/16/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) visit the body after death.						
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 11/16/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. H. K. M.D.		22e. ADDRESS 318 So. Union Ave Hf Md 2108				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/19/1982		23c. NAME OF CEMETERY OR CREMATORY Centre Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill Harford Md.		24. FUNERAL DIRECTOR NAME ADDRESS M. Gladden Kurtz Jarrettsville, Md.				
25a. DATE REC'D. BY REGISTRAR (DATE)		25b. REGISTRAR'S SIGNATURE [Signature]				

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



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JULY 1, 1954

U.S. DEPT. OF JUSTICE

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U.S.A.

WASHINGTON

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 5 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BESSIE WINIFRED KEITHLEY			2a. DATE OF DEATH MONTH 11 DAY 14 YEAR 82			2b. HOUR 6:18 AM				
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH Mar. DAY 21 YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.				
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1806 Van Bibber Road	
14. FATHER'S NAME FIRST Coleman MIDDLE Amos LAST Keithley			15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Virginia LAST Cullum			ADDRESS Darlington, Md, 21034 Mrs. Mary K. Walker, 2101 Shuresville Road				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-36-0254		17. INFORMANT Mrs. Mary K. Walker, 2101 Shuresville Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Severe A.B.C.U.D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diab. Mellitus (c) Memningitis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION 11-13-82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Memningitis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 1716 HARFORD ROAD		CITY OR TOWN FALLSTON		STATE MD
22a. I certify that (I) (this hospital) attended the deceased from 11-13-82 to 11-14-82 , that (I) (we) last saw the deceased alive on 11-13-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR M.D.			22e. ADDRESS 1716 HARFORD ROAD, FALLSTON MD 21034							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Calvary U.M. Cemetery		23d. LOCATION CITY OR TOWN Churchville COUNTY Harford STATE Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR NOV 16 1982		25b. REGISTRAR'S SIGNATURE John A. Grier		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove embalmers' papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 9 4 5 8			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Edith Edna KING				MONTH DAY YEAR 11-12-82				2:14 ^P _M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY HARFORD		13c. CITY OR TOWN STREET		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3552 Ady Rd	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BURKINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIETT H. KERNAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 220-07-8744		17. INFORMANT ADDRESS PATRICIA AYRES, WHITE HALL, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute subendocardial infarction 2501 Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last. (b) Diabetic acidosis (c) Renal failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-8, 1982 to 11-12, 1982, that (I) (we) last saw the deceased alive on 11-12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Brian T. Yeo, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yeo, M.D.				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Slate Ridge		23d. LOCATION CITY OR TOWN Delta		COUNTY York		STATE PA	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA						25a. DATE REC'D. BY REGISTRAR NOV 19 1982					
						REGISTRAR'S SIGNATURE John J. Lough					

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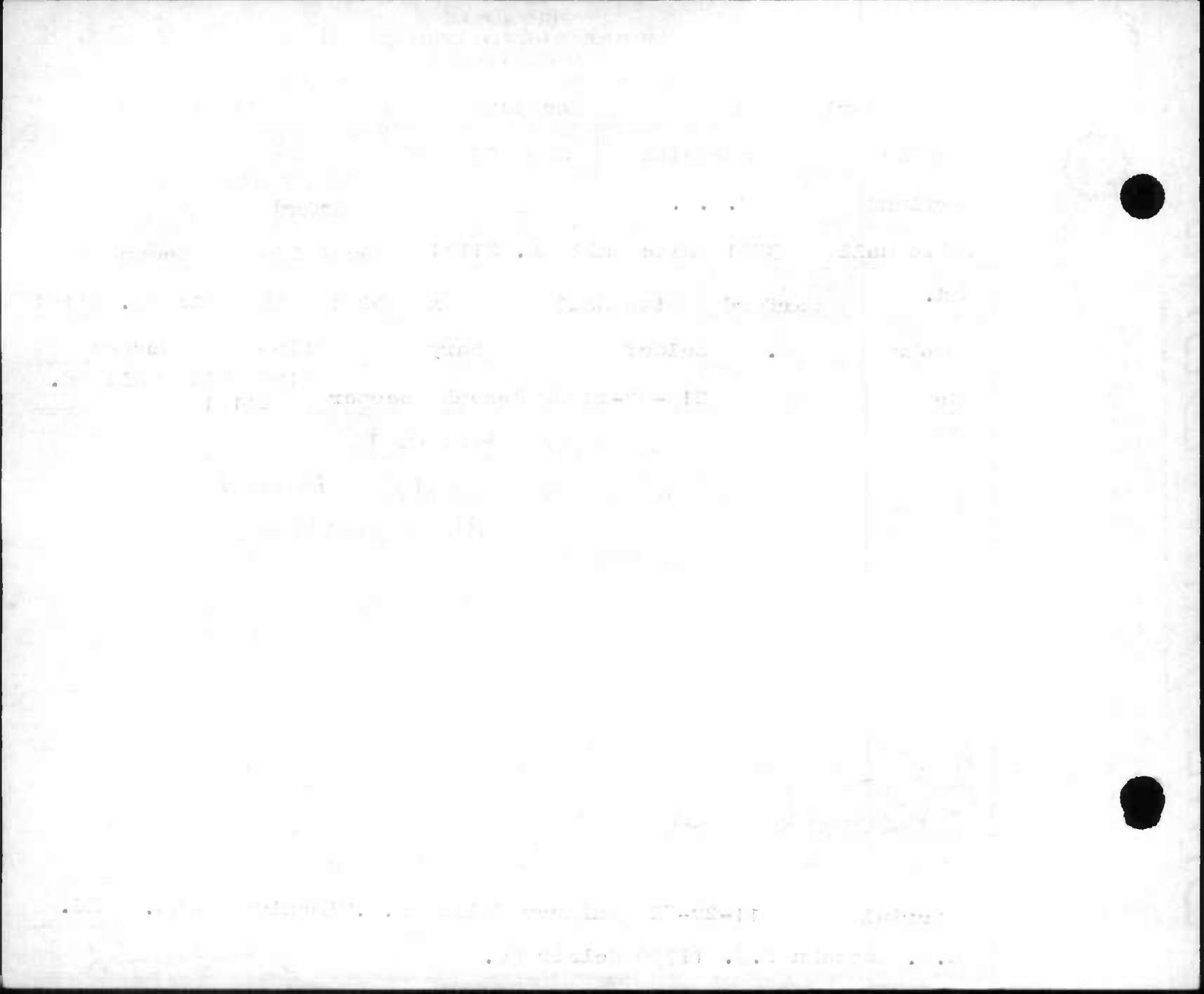
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Pearl M Koepper				2a. DATE OF DEATH MONTH 11 DAY 18 YEAR 82		2b. HOUR 8:25 ^A _M	
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH Jan DAY 27 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH White Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3201 White Hall Rd. 21161		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. Md. 13b. COUNTY Harford 13c. CITY OR TOWN White Hall				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3201 White Hall Rd. 21161	
14. FATHER'S NAME FIRST John MIDDLE H. LAST Zulauf				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ellen LAST Hoddes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A 216-03-1176D		17. INFORMANT Joseph Koepper ADDRESS 3139 White Hall Rd. 21161			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD CHF, Breastca Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) With metastasis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/8/82 , 19____, to____, 19____, that (I) (we) lost saw the deceased alive on 10/26/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kamal M. Jain DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kamal M. Jain MD				22e. ADDRESS 101 W. Ridgely Rd. Lutherville Md 21093			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-22-82		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley M.C.		23d. LOCATION CITY OR TOWN Timonium COUNTY Balt. STATE Md.	
24. FUNERAL DIRECTOR NAME E.F. Lassahn F.H. ADDRESS 11750 Belair Rd.				25. DATE RECD. BY REGISTRAR NOV 23 1982 REGISTRAR'S SIGNATURE John J. Conner			

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

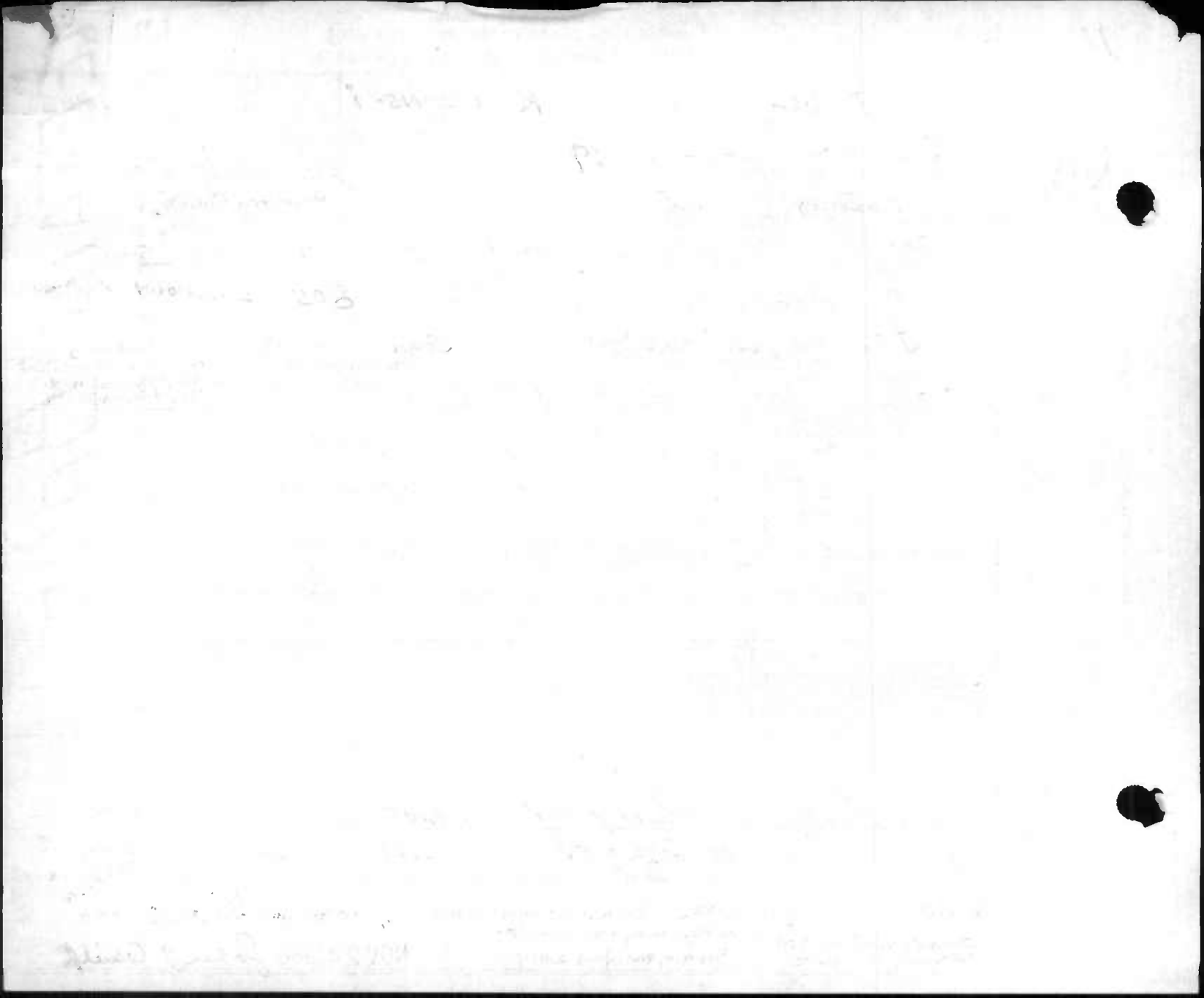
BP

DHM-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2 2 9 4 6 6	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST DEBRA ANN KOPCZYNSKI		MONTH DAY YEAR 11-21-82	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Female	White	MONTH DAY YEAR 2-8-63	LAST BIRTHDAY 19 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
New Jersey	U.S.A.	NEVER MARRIED WIDOWED DIVORCED	Harford County, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bel Air	Fallston General Hosp	Student	School
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
MD	HARFORD	Bel Air	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST John Raymond Kopezyński	FIRST MIDDLE LAST JOAN MARIE Moloughney	135-60-4913	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	
YES, NO, OR UNKNOWN No	(IF YES, GIVE WAR OR DATES) —	FATHER 838-3764 ADDRESS: Mrs. Schurz Kopezyński 805 Linwood Ave. Bel Air, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Multiple injuries			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Car accident			
(b) DUE TO, OR AS A CONSEQUENCE OF			
(c) DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Luis E Renjel		TITLE (SPECIFY) Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) LUIS E RENJEL		DATE SIGNED 11-21-82	
ADDRESS 464 Alliance 11 House of			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Nov. 24, 1982	Bel Air Memorial Gardens	Bel Air, Harford Co., Maryland 21014
24. FUNERAL DIRECTOR Joseph William Foster		25a. DATE REC'D. BY REGISTRAR	
Address: Woodberry & Williams St. Bel Air, Maryland 21014		25b. REGISTRAR'S SIGNATURE	
		NOV 24 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jaroslav (None) Krafca			2a. DATE OF DEATH MONTH DAY YEAR Nov. 14 1982		2b. HOUR 6:20 PM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 8 1906	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD		
10. CITY OR TOWN OF DEATH Abingdon	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 810 Long Bar Harbor Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Floor Lady		12b. KIND OF BUSINESS OR INDUSTRY Shoe	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford		13c. TOWN Abingdon	
14. FATHER'S NAME FIRST MIDDLE LAST John --- Janku			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie --- Zabochnik			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO 128-01-1341		17. INFORMANT ADDRESS Md. 21009 Louis Krajca, Jr., 815 Hilltop Ave, Abingdon		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF (c) stroke						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CVA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from 10-19 19 82 to Nov 19 82 , that (we) last saw the deceased alive on 10-19 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death, so state).						
22b. SIGNATURE William A. Tyson		DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-14-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Tyson		22e. ADDRESS Box 158 Kingsville Md. 21087				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 18, 1982	23c. NAME OF CEMETERY OR CREMATORY St. Francis de Sales Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford Md.		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 16 1982		
				25b. REGISTRAR'S SIGNATURE James E. Grier		

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "John" and "Kings" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CELIA Vileania KRAPF			2a. DATE OF DEATH MONTH DAY YEAR 11 7 1982		2b. HOUR 8-06 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 27, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAVRE-DE-GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Jarrettsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Powers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-12-7633		17. INFORMANT ADDRESS Theda V. Smoot Jarrettsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7970 IMMEDIATE CAUSE (a) old age DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Flora D. Jones		DEGREE Physician		22c. DATE SIGNED 11/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Flora D. Jones		22e. ADDRESS Havre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/10/1982	23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Md.	
24. FUNERAL DIRECTOR NAME Benjamin W. Kurtz				25a. DATE REC'D. BY REGISTRAR NOV 12 1982	
ADDRESS Jarrettsville, Md.				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



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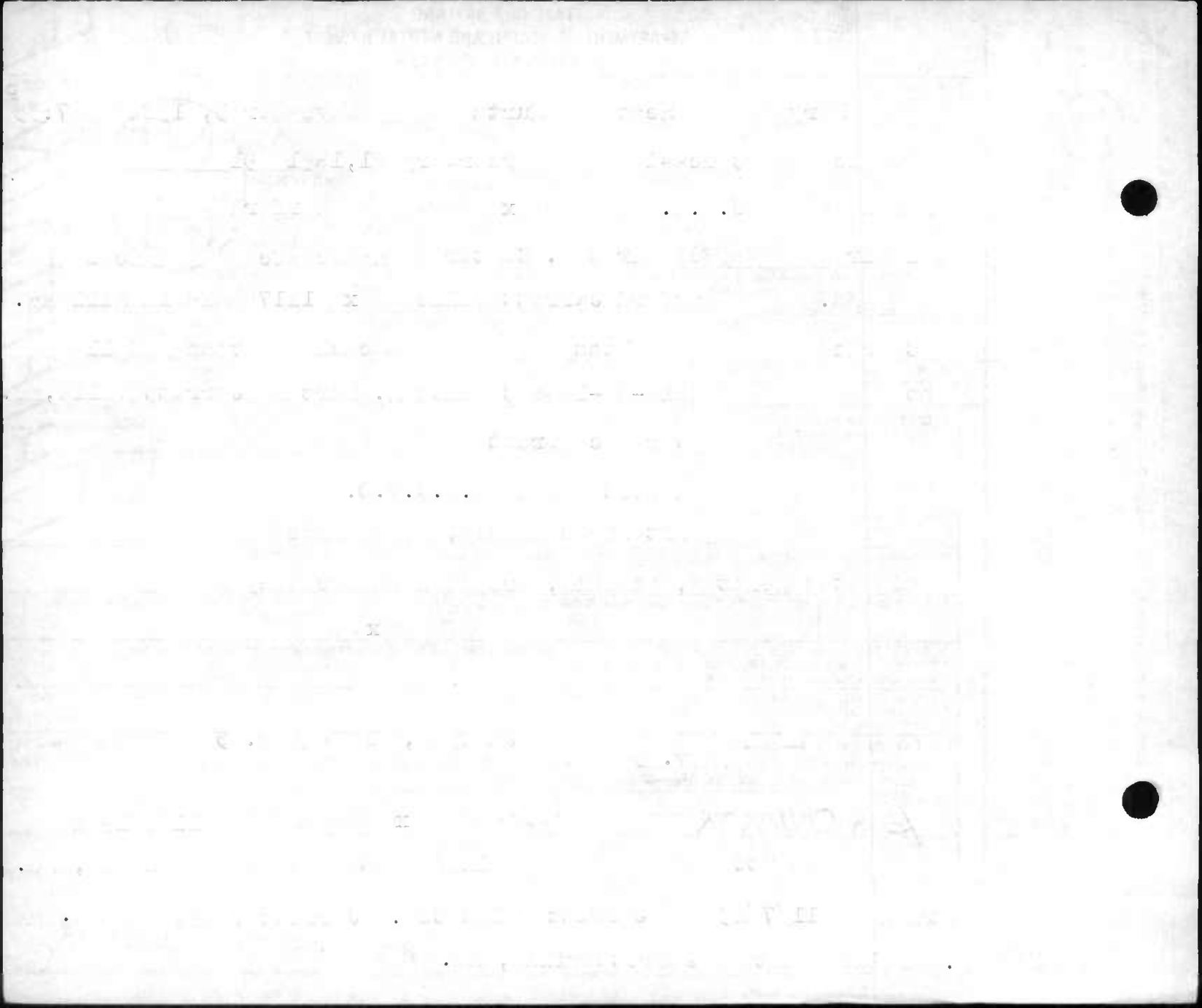
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Mary Hess Kurtz					2a. DATE OF DEATH Month Day Year November 3, 1982			2b. HOUR P 7:35 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH February 21, 1891		6. AGE (In years last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bel Air Con. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1117 Baldwin Mill Rd.	
14. FATHER'S NAME First Middle Last Charles Hess			15. MOTHER'S MAIDEN NAME First Middle Last Rachel Evans Ball						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 216-48-1048		17. INFORMANT Address Charles E. Kurtz Jarrettsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>Diabetes Melitus, amenia, renal insufficiency</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 28, 1982</u> , to <u>Nov. 3, 1982</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Nov. 3, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ben Oteyza</u>				22c. DATE SIGNED 11/3/1982		22d. PHYSICIAN'S NAME (Type) Ben Oteyza			
22e. ADDRESS 1131 Baltimore Pike Bel Air, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/7/1982		23c. NAME OF CEMETERY OR CREMATORY Jarrettsville Cem.		23d. LOCATION (City or Town) (County) (State) Jarrettsville Md.			
24. FUNERAL DIRECTOR M. Gladden Kurtz Jarrettsville, Md.				25a. REC'D BY REGISTRAR NOV 8 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 4

FOR
1- STATE
REGISTRAR

REG. NO.

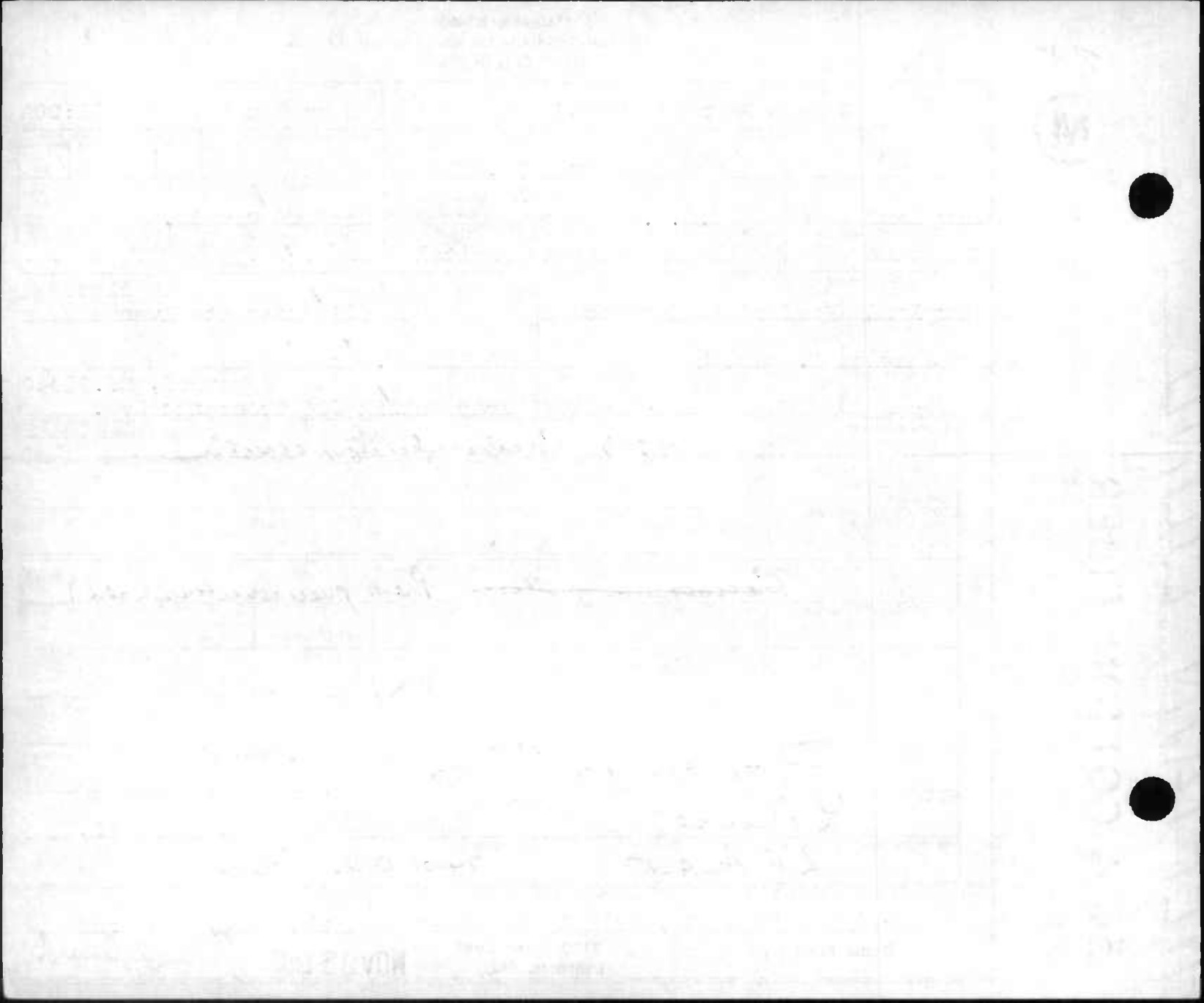
1. DECEASED NAME (TYPE OR PRINT) Joseph Raymond KUTLIK			2a. DATE OF DEATH MONTH DAY YEAR November 20, 1982			2b. HOUR 11:00A					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 18, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Steel Mill			
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21040 604 Crossgate Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Charles J. Kutlik			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian M. Gunn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					
16b. SOCIAL SECURITY NO. / WW 2			16c. SOCIAL SECURITY NO. 215-03-1288			17. INFORMANT ADDRESS Edgewood, Md. 21040 Marie Kutlik 604 Crossgate Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASAD. Cardiorespiratory arrest.</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic obstructive pulmonary disease. Prev. pneumonia (old).</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (this hospital) attended the deceased from <u>10/1/1973</u> to <u>present</u> , that (I) (we) lost saw the deceased alive on <u>10/11/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>L.F. Cawser</u>						DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Nov 22, 82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L.F. Cawser</u>						22e. ADDRESS <u>7401 Oiler Drive.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov 24, 82		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem Baltimore Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc.						ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Cawser</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 5

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dr. Frederick William LANE			2a. DATE OF DEATH MONTH DAY YEAR 11-19-82			2b. HOUR 51 10A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Springfield MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Engineer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. STATE Maryland			13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 37 LEE Street	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick L. LANE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie I. WADE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-22-8760		17. INFORMANT (SON) 1642-2411 Ext. 492 Mr. Frederick M. LANE		ADDRESS P.O. Box 455 Perry Point, Maryland 21902			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) severe COPD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11-17-1982 to 11-19-1982, that (I) (we) lost saw the deceased alive on 11-19-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.										
22b. SIGNATURE M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U.S. NAIR M.D.			22e. ADDRESS 1716 Hatfield Road - Bel Air MD 21014							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 22, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Co. Maryland 21014			
24. FUNERAL DIRECTOR Joseph William Foster Springfield Falls			W. Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE Joan J. Conner		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 9 4 6 6
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZA BETH MAE LEWIS			2a. DATE OF DEATH MONTH DAY YEAR 11 - 25 82		2b. HOUR 6 35 AM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8/25/22		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY BANKING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO	13c. CITY OR TOWN WHITE MARSH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21162 11540 PHILA. RD		
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND LEWIS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH LEWIS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 12 0192	17. INFORMANT ADDRESS JACQUELINE OSBORNE ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage. DUE TO, OR AS A CONSEQUENCE OF: (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Haberman Melanoma					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/23/82 , 19____, to 11/25/82 , 19____, that (I) (we) lost saw the deceased alive on 11/25/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. J. SWEATMAN	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/25/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. SWEATMAN	22e. ADDRESS FALLSTON GEN. Hosp. MILTON AVE FALLSTON				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11/27/82	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME J.G. CONNELLY	ADDRESS 300 MACE	25a. DATE REC'D. BY REGISTRAR DEC 1 - 1982	25b. REGISTRAR'S SIGNATURE Sam J. Connelly		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RONALD JAMES LITTLE			2a. DATE OF DEATH MONTH DAY YEAR November 19 1982		2b. HOUR 12³⁴ AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1949	6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.		
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GLASSWORK POINT	12b. KIND OF BUSINESS OR INDUSTRY CONCRETE PIPE	
13a. STATE MD			13b. COUNTY HARTFORD	13c. CITY OR TOWN HAVRE DE GRACE	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE - LITTLE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA - HURST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-54-8179	17. INFORMANT ADDRESS MR. BONNIE M. LITTLE, SAME		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 Hepatic Failure IMMEDIATE CAUSE (a) Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF (b) To be determined by autopsy. DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS OF LIVER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-20, 1982 , to 11-10, 1982 , that (I) (we) last saw the deceased alive on 11-10, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED/ NOV 11 '82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAN D. SOMERVILLE		22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-12-82	23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE DE GRACE HARTFORD MD.
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL F. H. P.A. HAVRE DE GRACE MD			25a. DATE REC'D. BY REGISTRAR NOV 15 1982	25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

STREET ADDRESS
CITY AND STATE
ZIP CODE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene as the basis for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROXIE MANNING			2a. DATE OF DEATH MONTH DAY YEAR November 24/82		2b. HOUR 5:30 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 29 01	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ABINGDON, VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH Aberdeen	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1425 Old Stepheny Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress	12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		
13c. CITY OR TOWN Parkville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 2204 Taylor Avenue			14. FATHER'S NAME FIRST MIDDLE LAST JAMES HICKS		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b. SOCIAL SECURITY NO. 4029			17. INFORMANT ADDRESS Flora Fitzgerald 2204 Taylor Avenue 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Conjunctive Heart Failure DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (No data) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Bron Syndrome, COPD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1; OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-1-82 , to 11-22-82 , that (I) (we) last saw the deceased alive on 11-22-82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE Peter P. Goodman, M.D.		DEGREE M.D.		22c. DATE SIGNED 11-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter P. Goodman, M.D.		22e. ADDRESS 8 Law St. Aberdeen, Md 21001			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE 11/26/82		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring Rd.			
25a. DATE REC'D. BY REGISTRAR NOV 24 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, no medical certificate need be completed at this time.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 6 9

REG. NO.

1 - FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) AGNES ELIZABETH McCASLIN		2a. DATE OF DEATH MONTH DAY YEAR 11 12 82		2b. HOUR 2:55 A.M.	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 14, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DEL.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MD.		13b. COUNTY CECIL		13c. CITY OR TOWN CONOWINGO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM P. CARR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES E. CARR		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-14-2725	
17. INFORMANT MRS. BETTY ORR		18. ADDRESS RISING SUN, MD. 21911		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Dr. W. J. Mullen</i>		DEGREE MD.		22c. DATE SIGNED 11/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. J. MULLEN		22e. ADDRESS FALLSTON GEN. HOSP. FALLSTON, MD.		23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 11-14-1982	
23c. NAME OF CEMETERY OR CREMATORY HARMONY CHAPLE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CONOWINGO CECIL MD.		24. DATE REC'D. BY REGISTRAR NOV 17 1982		25. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

4241

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Erma Claire McComas			2a. DATE OF DEATH MONTH DAY YEAR November 27 1982		2b. HOUR MIN. 2:30 A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1920		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Clerk	12b. KIND OF BUSINESS OR INDUSTRY Liquor Store
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 612 Front Street 21903	
14. FATHER'S NAME FIRST MIDDLE LAST George Goodrich		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes McNeive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-16-6463		17. INFORMANT ADDRESS Carolyn A. McComas 903 Quarry Rd., No. 19 Havre de Grace, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Ca, Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 82 , to 11-27 , 19 82 , that (I) (we) last saw the deceased alive on 11-27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. de la Cruz		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. de la Cruz		22e. ADDRESS San Antonio			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 30, 1982	23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Hartford Maryland
24. FUNERAL DIRECTOR NAME Dee A. Patterson & Son			ADDRESS Perryville, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 7 1982

BP _____

STATE OF NEW YORK
IN SENATE
January 2, 1925

REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF AGRICULTURE

REPORT

STATE OF NEW YORK
DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 9 4 7 1	
1 - FOR STATE REGISTRAR (Martha ANN McCutcheon)				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
FIRST MIDDLE LAST MARTHA ANN McCutcheon				11-19-82	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
FEMALE		White		10-29-28	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Baltimore City Maryland		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH #AR Ford MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Fallston		Fallston General Hospital		Sales Clerk	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Catalog Sales-Store		13 SHANNON Dr.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
John Clarence Snyder		Alice Elizabeth Lehr		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) ADDRESS		17. INFORMANT (Husband) ADDRESS	
213-26-6529		Mrs. William R. McCutcheon		13 Shannon Drive Bel Air Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1509 Respiratory insufficiency				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced carcinoma of esophagus					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8/26/82		Carcinoma of esophagus		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/12/82, 1982, to 11/19, 1982, that (I) (we) lost saw the deceased alive on 11/18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE SIGNED	
IAN D. SOMERVILLE		400 LEWIS ST HAVRE DE GRACE		Nov 19 82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Nov. 20, 1982		Greenmount Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Baltimore, Maryland		NOV 23 1982		John J. Carver	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
Joseph William Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		NOV 23 1982	

BP

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a copy of the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE LAWRENCE MIDDLEBROOK			2a. DATE OF DEATH MONTH DAY YEAR 11 27 82			2b. HOUR 3 ⁵⁵ A.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City, NY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Rubber			
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Stanley -- Middlebrook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie -- Plant			13e. STREET ADDRESS 4901 Philadelphia, Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS 21001 Mrs. Frances E. Middlebrook, Aberdeen, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell CA Rt Lung with 1629 DUE TO, OR AS A CONSEQUENCE OF (b) metastasis to skin. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1981, 19, to 11 27, 19 82, that (I) (we) last saw the deceased alive on 11-26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 1629		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-27-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.				22e. ADDRESS 1908 HARFORD RD, MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Harford Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 29 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			

MEDICAL CERTIFICATION



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a list or a report, organized in a structured format.]

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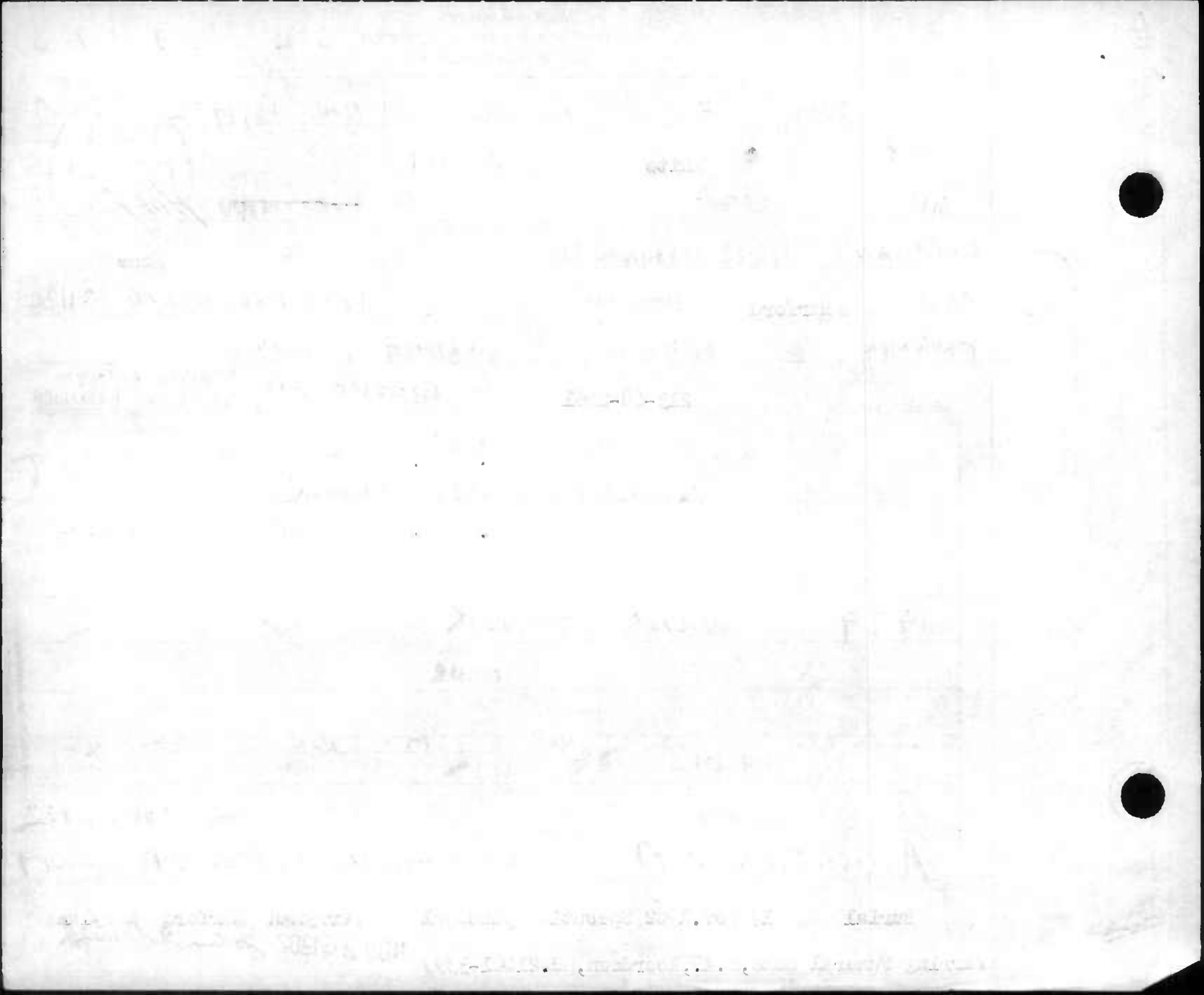
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be taken to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called on.

DHMH - 16.50M 1/81
(VRA 15, 4)

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 9 4 7 3		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOEL B MITCHELL				2a. DATE OF DEATH MONTH DAY YEAR NOV. 15, 1982		2b. HOUR 10:30 AM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 24 69		6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) COUNTRY MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PERRYMAN HARFORD MD	
10. CITY OR TOWN OF DEATH PERRYMAN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1642 PERRYMAN RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN PERRYMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK O MITCHELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA PEARCE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-68-2461	
17. INFORMANT A. GLAZIER MD		ADDRESS JOHNS HOPKINS HOSPITAL, BALTIMORE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1890 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC WILMS TUMOR (c) WILMS TUMOR RIGHT KIDNEY 39 YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 NONE							
19a. DATE OF OPERATION 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED WILMS TUMOR		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NONE		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from NOV 14 1982 to NOV 15 1982, that (we) last saw the deceased alive on NOV 14 1982, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death.		22b. SIGNATURE A. Glazier MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED NOV. 15, 1982		22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. GLAZIER MD		22e. ADDRESS JOHNS HOPKINS HOSPITAL DEPT. ONCOLOGY		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE 17 Nov. 1982		23c. NAME OF CEMETERY OR CREMATORY Spesutia Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE Perryman Harford Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399	
25a. DATE REC'D BY REGISTRAR NOV 26 1982		25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S OFFICE [Signature]		25d. REGISTRAR'S PHONE NO. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 9 4 7 4			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR			
FIRST MIDDLE LAST HOMER L. MURRAY				2b. HOUR 11 ¹⁰ / _{P.M.}			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 3 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAURE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FORMOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY Govt. EMPLOYED	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jeff W. Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Hattie Lee Mitchell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 462-05-8431	
17. INFORMANT ADDRESS Margaret L. Murray - 116 Balto. St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recurrent low GI bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-12 hours			
19a. DATE OF OPERATION 11/19/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Low GI bleeding		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-13, 19 82, to 11-25, 19 82, that (I) (we) last saw the deceased alive on 11-25, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. DATE SIGNED 11/27/82			
22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE NOV 29-NOV 2		23c. NAME OF CEMETERY OR CREMATORY Bel Air New Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR HARRIS Funeral Home Aberdeen Md 21001				25. DATE REC'D BY REGISTRAR IN REGISTRAR'S OFFICE DEC 6 1982			

1992-1993
 1994-1995
 1996-1997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 29 475	
1. FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Henry Peteresen				Nov. 6 82	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		white		3 16 1912	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		USA		70 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Harford		Harford Memorial Hosp		Harford MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Retired		U.S. Navy			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Harford		Perryman	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. STREET ADDRESS	
Harry Peteresen		Anna Dill		1838 Perryman Road	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
Yes		WW-LI Navy 212-30-3611		Poway, Calif. 92064	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?	
PART 1. DEATH WAS CAUSED BY:		Oct 19 '82		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IMMEDIATE CAUSE (a) Cardiac arrest				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct suspected				YES <input type="checkbox"/> NO <input type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of right lung & vocal chords					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. INJURY OCCURRED		21h. PLACE OF INJURY		21i. LOCATION	
21j. INJURY OCCURRED		21k. PLACE OF INJURY		21l. LOCATION	
22a. I certify that (I) (this hospital) attended the deceased from Nov 5, 19 82, to Nov 6, 19 82, that (I) (we) lost saw the deceased alive on Nov 6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
[Signature]				Nov 6 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
IAN D. SOMERVILLE		400 LEWIS ST HARVARD DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal/Burial		11/9/82		Sands Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Tarring Funeral Home, P.A.,		Aberdeen, Md. 21001-3		NOV 15 1982	



Handwritten notes and a table. The table has several columns with headers that are difficult to read but appear to include 'Name', 'Address', and 'Remarks'. There are handwritten entries in the rows, including 'John Smith' and '123 Main St'. A large 'X' is drawn across the middle of the table.

Handwritten notes and a large, faint circular stamp. The notes are mostly illegible due to fading and bleed-through from the reverse side of the page.

Handwritten notes and a large, faint circular stamp. The notes are mostly illegible due to fading and bleed-through from the reverse side of the page.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 7 6

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E LAST BOHLMAN			2a. DATE OF DEATH MONTH 11 DAY 22 YEAR 82			2b. HOUR 5:45 AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 1 DAY 26 YEAR 1884		
6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			10. CITY OR TOWN OF DEATH FALLSTON		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2644 Dulaney St. #21223		
14. FATHER'S NAME FIRST ? MIDDLE ? LAST ?			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE ? LAST ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
16b. SOCIAL SECURITY NO. 213-14-4954			17. INFORMANT Rd. 3 Box 247 Delta, Pennsylvania 17316 Mr. Edward C. Alley			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CONGESTIVE HEART FAILURE		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Barry A. Wohl DEGREE		
22c. DATE SIGNED 11/22/82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY A. WOHL			22e. ADDRESS 131 S. UNION AVE HARFORD, MD 21078		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-26-82			23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			24. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. #21229			25a. DATE REC'D. BY REGISTRAR DEC 1 1982		
25b. REGISTRAR'S SIGNATURE John J. Conner								

1. Name of the plant or animal: *...*
2. Name of the collector: *...*
3. Date of collection: *...*
4. Locality: *...*
5. Description of the specimen: *...*
6. Remarks: *...*

20

1/1/11

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 7 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Robert Lee Presbury				2a. DATE OF DEATH MONTH DAY YEAR November 28 1982		2b. HOUR 1:05 AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR April 15, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler fireman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Presbury		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Mary Jackson		16. STREET ADDRESS 107 Rock Spring Church Rd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-32-0796		17. INFORMANT ADDRESS William H. Presbury Jr. Bel Air, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 4292 DUE TO, OR AS A CONSEQUENCE OF: (b) A.S.C.D. DUE TO, OR AS A CONSEQUENCE OF: (c) Chronic Brain Syndrome PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) U.S.A.							
19a. DATE OF OPERATION 11-28-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Brain Syndrome		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11-28-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Chronic Brain Syndrome			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Harford		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Forest Hill, Harford, Md.			
22a. I certify that (I) (this hospital) attended the deceased from 11-16-82 to 11-28-82 , that (I) (we) last saw the deceased alive on 11-28-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE M.D.		22c. DATE SIGNED 11/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.				22e. ADDRESS Harford de Grace, Ind. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/1/1982		23c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford, Md.	
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz				ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 1 1982	
				25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 7 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George ERNEST Reynolds				2a. DATE OF DEATH MONTH DAY YEAR Nov. 8 1982		2b. HOUR 3:15 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 6 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAURELEGRAD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Tender Ret. U.S. Gov.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF FURNISH HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN Port Deposit				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 180 Funk Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Cleveland Reynolds				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b. SOCIAL SECURITY NO. 218-03-1641		17. INFORMANT ADDRESS Mrs. Stella M. Reynolds (Wife) Same Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-3 19 82, to 11-8 19 82, that (I) (we) lost saw, the deceased alive on 11-8 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leticia S. Galvez				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leticia S. Galvez				22e. ADDRESS 625 S. UNION AVE HAURELEGRAD MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11-10-1982		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cotora Cecil Md.	
24. FUNERAL DIRECTOR Rising Sun, Md				25a. DATE REC'D. BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE John J. Carter	

1. Name of the plant or animal: *...*
2. Name of the collector: *...*
3. Date of collection: *...*
4. Locality: *...*
5. Description of the specimen: *...*
6. Remarks: *...*

7. Name of the collector: *...*
8. Date of collection: *...*
9. Locality: *...*
10. Description of the specimen: *...*
11. Remarks: *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 9 4 7 9	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST Elizabeth Lillian Ruby				MONTH DAY YEAR Nov 2 1982	
3. SEX				2b. HOUR	
Female				6:05 P	
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
White		MONTH DAY YEAR 10 8 1909		73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Harre de Grace		Harford Memorial Hospital		Homemaker	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
MD 21001		Harford		714 Carpins Run Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY	
FIRST MIDDLE LAST William Jerome Baker		FIRST MIDDLE LAST Sarah Elizabeth Flowers		Home	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-22-2720		Robert I. Ruby, 3307 Dublin School Rd., Street, Maryland 21154	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio-pulmonary failure					
4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive ASCOD					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-2, 1982, to 11-2, 1982, that (I) (we) lost saw the deceased alive on 11-2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
J. F. Lee				11/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
J. T. Lee		Union Med. Clinic Hds Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5 Nov. 1982		Mt. Zion Methodist	
24. FUNERAL DIRECTOR NAME		24b. LOCATION CITY OR TOWN COUNTY STATE		25a. DATE REC'D. BY REGISTRAR	
Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399		Bel Air Harford Maryland		NOV 8 1982	
25b. REGISTRAR'S SIGNATURE					

THE NATIONAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JAN 10 1964

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[The following section contains several lines of extremely faint, illegible text, likely representing a memorandum or report body.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 8 0

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Fred Louis Rush, Sr.			2a. DATE OF DEATH MONTH DAY YEAR Nov. 19, 1982		2b. HOUR 11:28 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 17 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 61	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? Usa		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAVERC de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jackson Rush		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Wiulder		13e. STREET ADDRESS 900 Calvary Road - 21028			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-II 225-18-9759		17. INFORMANT ADDRESS Maryland 21028 Fred L. Rush, Jr., 900 Calvary Rd., Churchville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG - RETROPERI- TONIC METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) the hospital attended the deceased from SEPT 13, 1982 , to NOV 20, 1982 , that (I) we saw the deceased alive on NOV 19, 1982 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I we did not) view the body after death.							
22b. SIGNATURE B.J. Plunkett, Jr. M.D.				DEGREE M.D.		22c. DATE SIGNED 11-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.J. Plunkett, Jr. M.D.				22e. ADDRESS 617 W. Bel Air Ave., Aberdeen, Md. 21001			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/22/82		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001-33				25a. DATE REC'D. BY REGISTRAR NOV 24 1982			
				REGISTRAR'S SIGNATURE John J. Carver			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 8 1

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Albert Schneider			2a. DATE OF DEATH MONTH DAY YEAR 11-24-82		2b. HOUR 10 ⁰⁵ P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10-23-09	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		
10. CITY OR TOWN OF DEATH Belair	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY KOPPER'S CO.
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3022 Putty Hill Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John Albert Schneider	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Miller		17. ADDRESS FAMILY RECORDS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-5819				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 3320 IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Parkinson's Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>3/19</u> , 19 <u>82</u> , to <u>11/24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Andrew Nowakowski MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/24/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD		22e. ADDRESS 125 W. MAIN ST. BELAIR, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11-27-1982	23c. NAME OF CEMETERY OR CREMATORY FORK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FORK BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS EVANS FUNERAL CHAPEL 8800 HARFORD ROAD		25a. DATE REC'D. BY REGISTRAR NOV 30 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Casper</u>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 29482	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN CARL Smeltzer										2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR 11 20 19 82	
2. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 2 20 10 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2b. HOUR 12 ⁰⁰ P.M.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 20 19 82 2d. HOUR 12 ⁰⁰ P.M.	
10. CITY OR TOWN OF DEATH Fallston - 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallsfm Genuine Hosp 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor 12b. KIND OF BUSINESS OR INDUSTRY G. L. Martin											
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD. 13c. COUNTY HARFORD 13d. CITY OR TOWN Bel Air 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13f. STREET ADDRESS 103 Lexington Rd. Belair, Md.											
14. FATHER'S NAME FIRST MIDDLE LAST Clyde L. Smeltzer 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmina Corl											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 165-16-20 93 17. INFORMANT Mrs. Anna M. Smeltzer, Belair, Md. 21014											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CORONARY Heart Disease Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) ASCVD. (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Luis E. Renjel TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-20-82											
EXAMINER'S NAME (TYPE OR PRINT) Luis E Renjel ADDRESS 464 Allamore St Harford, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 11-24-1982 23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens Belair Harford, Md. 23d. LOCATION CITY OR TOWN COUNTY STATE											
24. FUNERAL DIRECTOR NAME Edgar F. Lassahn Funeral Home, 11750 Belair Rd ADDRESS 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2

2

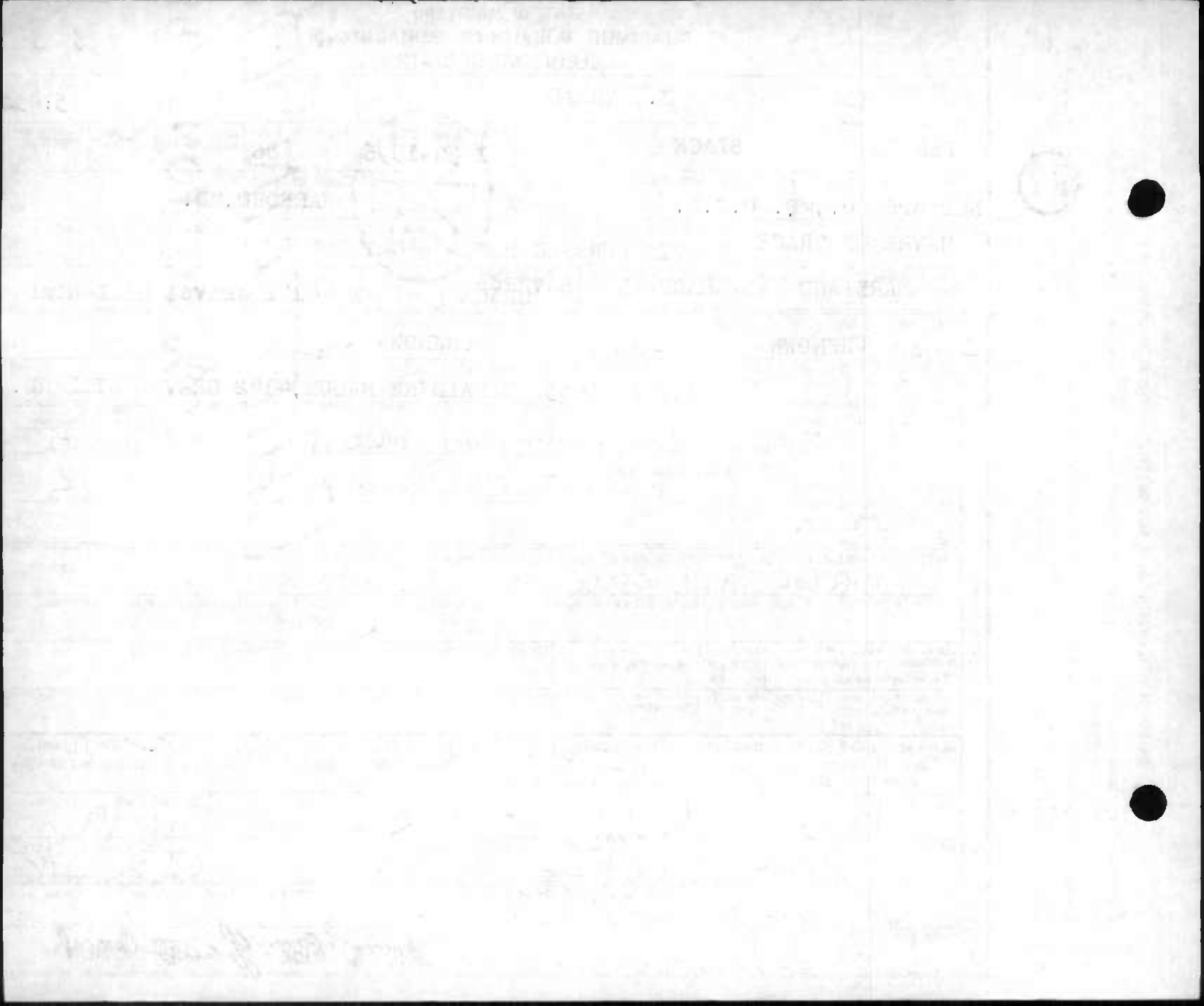
9

4

8

3

1. DECEASED-NAME (Type or print) IDA First Middle B. SNEAD Last			20. DATE OF DEATH 11 Month 3 Day 82 Year		26. HOUR 5:45 AM
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH 1-30-1896	
6. AGE (In years and birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Harford CO., MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH HARFORD, MD.					
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BREVIN NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during normal working life, even if retired.) CATERER	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) HARFORD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4142 GRAVEL HILL ROAD			
14. FATHER'S NAME First Middle Last LAWSON UNKNOWN HARRIS			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN SUSAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 162-12-1465		17. INFORMANT Address GERALDINE HAGUE, 4142 GRAVEL HILL RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BREAST CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1749					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>DIFFUSE ATHEROSCLEROTIC DISEASE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/8</u> , 19 <u>82</u> , to <u>11/3</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Barry A. Wohl</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 11/3/82	
22d. PHYSICIAN'S NAME (Type) BARRY A. WOHL		22e. ADDRESS 131 S. UNION Avenue HARVRE DE GRACE MD. 21078			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-9-82		23c. NAME OF CEMETERY OR CREMATORY St James Grave Hill	
23d. LOCATION (City or Town) (County) (State) Harvde de Grace Harford Md					
24. FUNERAL DIRECTOR ADDRESS ARNOLD BEARD 353 Fountain St HDG, Md.		25a. RECD BY REGISTRAR NOV 9 1982		25b. REGISTRAR'S SIGNATURE G. J. G. J.	



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 2 2 9 4 8 4			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Mitchell SOva <i>ELIZABETH MITCHELL SOVA</i>				2a. DATE OF DEATH MONTH DAY YEAR 11-22-82		2b. HOUR MIN. 4:35 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1930		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. 52	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY Shoe	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Paul Hoffman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Amelia Keithley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-26-2173		17. INFORMANT ADDRESS Mrs. Regina Kelley, Aberdeen, Md. 21001			
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART 1. DEATH WAS CAUSED BY 1539 IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 82			
22a. I certify that (I) (this hospital) attended the deceased from 11/21/82 to 11/22/82 that (I) (we) lost saw the deceased alive on 11/21/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Willard P. Amos</i>		DEGREE		22c. DATE SIGNED 11/22/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amos		22e. ADDRESS 2404 Pleasantville Rd, Fallston, Md 21047		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Calvary U.M. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Churchville Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 23 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Lough</i>	

MEDICAL CERTIFICATION

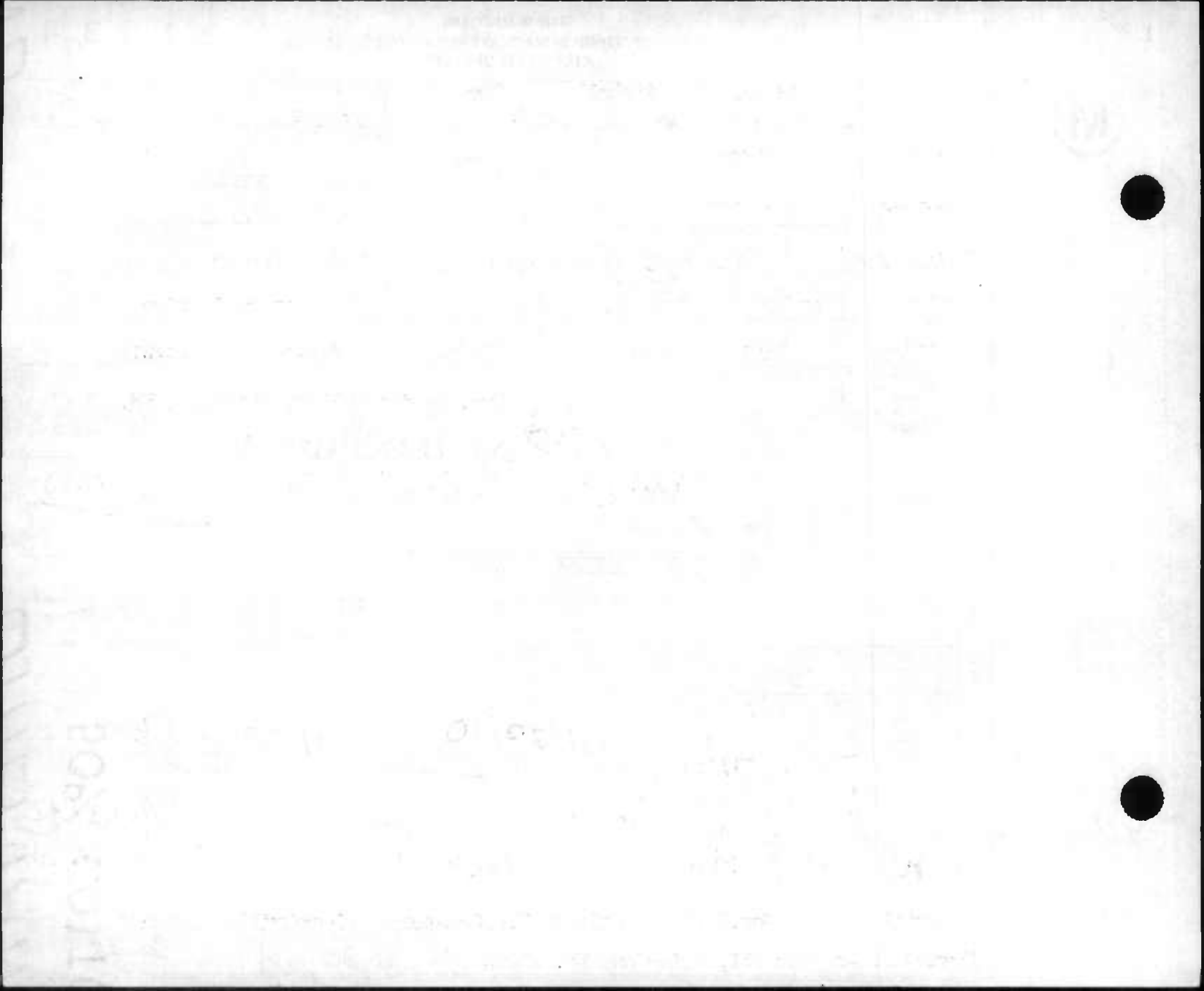
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
DALE						SPARKS		11		15		19		82		7	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY	
Male		Black		02 15 59		23 YRS.						11 15 1982					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Struthers, Ohio		USA		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Harford County					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Aberdeen, Md.		Kirk US Army Health Clinic		Soldier		Military											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Ohio				Struthers		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		43 Narcissus Avenue									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Charles		Laura															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
yes		1978-Present		268-60-5900		Edna Bell/aunt/Struthers, Ohio											
18. CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c).)		PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
9139		IMMEDIATE CAUSE (a) Postural Asphyxia															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF															
		(b) DUE TO, OR AS A CONSEQUENCE OF															
		(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Alcohol Intoxication															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/15/82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Asphyxia by bed pillow											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
		Army Housing		Aberdeen Proving Grounds						Md.							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		Nov 17, 1982											
EXAMINER'S NAME (TYPE OR PRINT)		Ronald L. Reeves, M.D. MAJ. MC		13172 Holly Loch Lane		Highland, Maryland		20777									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		Nov 20 1982		Belmont Park Cemet.		Youngstown, Ohio											
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE											
Marshall's Funeral Home		4217 9th St. NW		Washington, D.C.		NOV 24 1982											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 8 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCY E. STANDIFORD				2a DATE OF DEATH MONTH DAY YEAR 11 7 1982		2b HOUR 3:55P M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 3 1894		6 AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10 CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 Baltimore Street 21001		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Aberdeen				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11 Baltimore Street	
14 FATHER'S NAME FIRST MIDDLE LAST Elmer E. Eagleton				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary D. Johnson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-2305		17 INFORMANT Dr. Willard E. Standiford, #1, Englewood Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) old age DUE TO, OR AS A CONSEQUENCE OF c) Uremic Toxemia Infection PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-20-59 , to 11-7-82 , that (we) last saw the deceased alive on 11-5-82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Peter P. Rodman, M.D.				DEGREE		22c. DATE SIGNED 11-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter P. Rodman M.D.				22e. ADDRESS 8 Law St. Aberdeen, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/10/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Christian Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Maryland	
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399				25a. DATE REC'D. BY REGISTRAR NOV 15 1982			
25b. REGISTRAR'S SIGNATURE John J. Smith							

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Page 1 of 1

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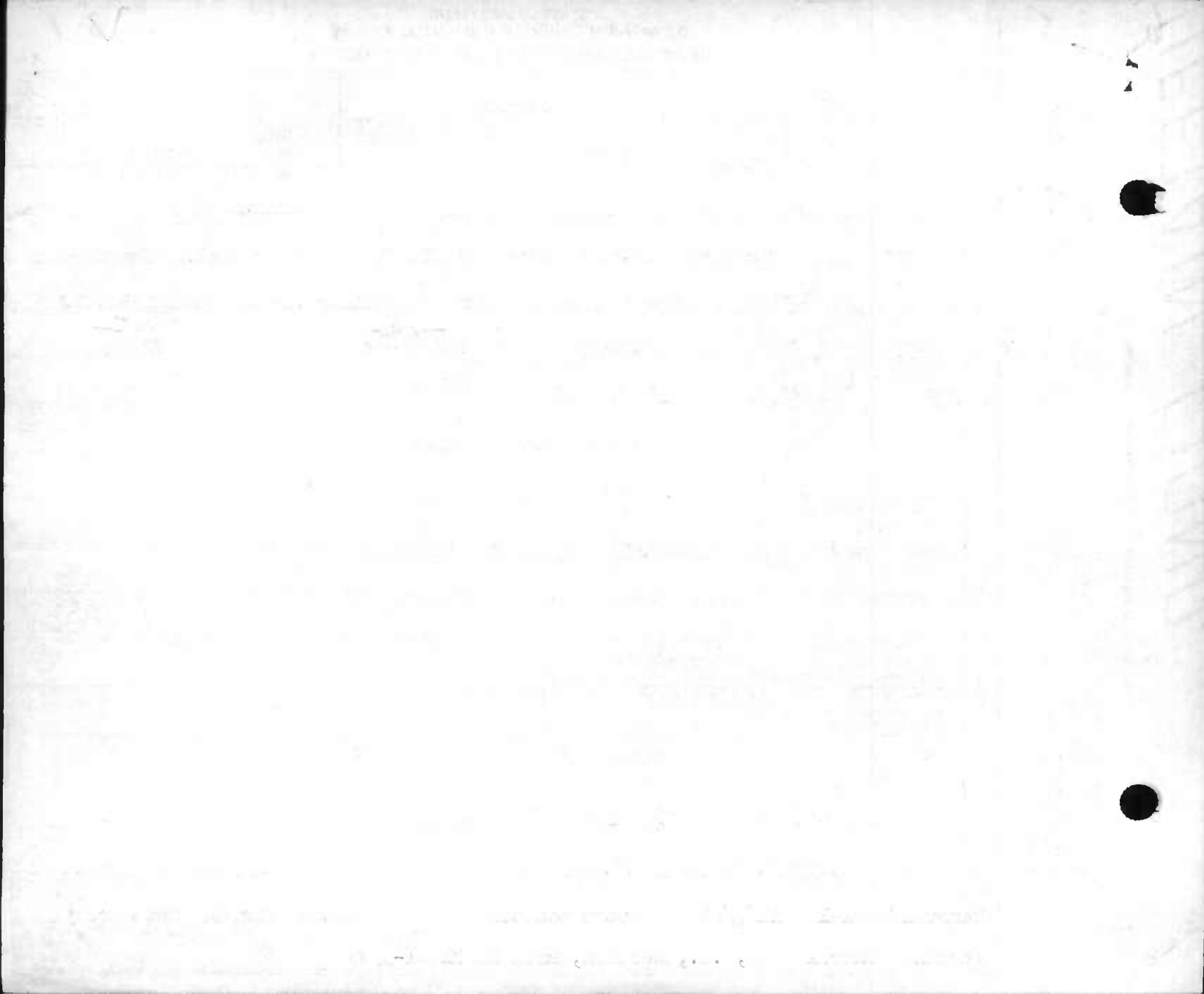
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 29487			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) Earl S. Straway										2b. DATE KNOWN OF DEATH 11-4 1982			
3. SEX M 4. RACE W 5. DATE OF BIRTH 8 8 27 55 6. AGE (IN YEARS) 55 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 11-4 1982			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NJ 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Aberdeen 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Tuckaway Manor, Aberdeen, MD 21001 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer Tech. 12b. KIND OF BUSINESS OR INDUSTRY Government													
13a. STATE NJ 13b. COUNTY Sussex 13c. CITY OR TOWN Budd Lake 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS Kings VLG-C36 Budd Lake, NJ													
14. FATHER'S NAME (FIRST MIDDLE LAST) Harry NMN Straway 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Wrightman Tillie													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes 16b. SOCIAL SECURITY NO. USN -WWII 17. INFORMANT Wallet													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Luis E. Renjel M.D. Deputy MEDICAL EXAMINER										TITLE (SPECIFY)		DATE SIGNED 11-4-82	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St. Havre De Grave, MD										21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial 23b. DATE 11/7/82 23c. NAME OF CEMETERY OR CREMATORY Newton Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Newton Sussex New Jersey													
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Maryland ADDRESS 21001-3399													

NOV 8 1982



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANIE ELIZABETH STREETT			20. DATE OF DEATH MONTH DAY YEAR 11-8-82			2b. HOUR MIN. 8:05 AM				
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3104 Rocks Road 21084	
14. FATHER'S NAME FIRST MIDDLE LAST Levi Boyd Campbell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Helen Amos			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-18-5173	
17. INFORMANT ADDRESS Hazel I. Streett Baltimore, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Mesothelioma (C) Lungs DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 4 mths.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: g										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1982 , to 11/8 , 19 82 , that (I) (we) last saw the deceased alive on 11/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Randall C. Cronin, Jr.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Randall C. Cronin, Jr.			22e. ADDRESS 721 Wheeler School Rd. Whiteford, Md 21160							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/11/1982		23c. NAME OF CEMETERY OR CREMATORY William Watters		23d. LOCATION CITY OR TOWN COUNTY STATE Coopstown, Harford, Md.			
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz			ADDRESS Jarrettsville, Md.			25a. DATE REC'D. BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE John J. Canine		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked at item 18 show any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Anna Marie Strenick				2a. DATE OF DEATH MONTH DAY YEAR November 8, 1982		2b. HOUR 9:48 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 30 01		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Fallston, MD	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Custodian	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3111 Vulcan Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST John Gombala		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 216-16-3163		17. INFORMANT ADDRESS Mary Stoffa 3111 Vulcan Road 21222		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) MASSIVE INTRACEREBRAL BLEEDING - 12 hrs DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) ANTICOAGULANT THERAPY			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-8-82 to 11-8-82 , that (I) (we) last saw the deceased alive on 11-8-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/9/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR M.D.		22e. ADDRESS 1716 HARFORD ROAD; FALLSTON					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-11-82		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME C.S. Zeiler & Son Inc. 6224 Eastern Avenue				25a. DATE REC'D. BY REGISTRAR NOV 10 1982		25b. REGISTRAR'S SIGNATURE John J. Gairish	

Office Memorandum - (Circular)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 9 4 9 0
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary G Suchsbradt		2a. DATE OF DEATH MONTH DAY YEAR Nov. 7 1982	
3. SEX FEMALE		2b. HOUR 2:35 AM	
4. RACE WHITE		6. AGE (IN YEARS LAST BIRTHDAY) 89	
5. DATE OF BIRTH MONTH DAY YEAR SEPT. 3 1893		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY HARFORD	
13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 153 BLOOMSBURY AVE			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM F. AWALT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY F. CARSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-07-5150	
17. INFORMANT ADDRESS 119 WEBER ST. HAYREDE GRACE MD			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease Aortic Stenosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Fracture of right Femur and Humerus ② Autoimmune hemolytic anemia			
19a. DATE OF OPERATION 11-3-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-3-82 to 11-7-82, that (I) (we) lost saw the deceased alive on 11-7-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE SANG W. KIM		22c. DATE SIGNED NOV. 8, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM		22e. ADDRESS 308 S. Union Ave. Havre de Grace, Md 21094	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Nov. 9, 1982	
23c. NAME OF CEMETERY OR CREMATORY LODON PARK CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MD	
24. FUNERAL DIRECTOR NAME MITCHELL F.H. P.A.		25a. DATE REC'D. BY REGISTRAR NOV 12 1982	
25b. REGISTRAR'S SIGNATURE John J. Smith			

1. Name of the plant: *...*

2. Name of the collector: *...*

3. Date of collection: *...*

4. Locality: *...*

5. Description of the plant: *...*

6. Uses: *...*

7. Remarks: *...*

8. Number of specimens: *...*

9. Name of the collector: *...*

10. Date of collection: *...*

11. Locality: *...*

12. Description of the plant: *...*

13. Uses: *...*

14. Remarks: *...*

15. Number of specimens: *...*

16. Name of the collector: *...*

17. Date of collection: *...*

18. Locality: *...*

19. Description of the plant: *...*

20. Uses: *...*

21. Remarks: *...*

22. Number of specimens: *...*

23. Name of the collector: *...*

24. Date of collection: *...*

25. Locality: *...*

26. Description of the plant: *...*

27. Uses: *...*

28. Remarks: *...*

29. Number of specimens: *...*

30. Name of the collector: *...*

31. Date of collection: *...*

32. Locality: *...*

33. Description of the plant: *...*

34. Uses: *...*

35. Remarks: *...*

36. Number of specimens: *...*

37. Name of the collector: *...*

38. Date of collection: *...*

39. Locality: *...*

40. Description of the plant: *...*

41. Uses: *...*

42. Remarks: *...*

43. Number of specimens: *...*

44. Name of the collector: *...*

45. Date of collection: *...*

46. Locality: *...*

47. Description of the plant: *...*

48. Uses: *...*

49. Remarks: *...*

50. Number of specimens: *...*

(M)

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

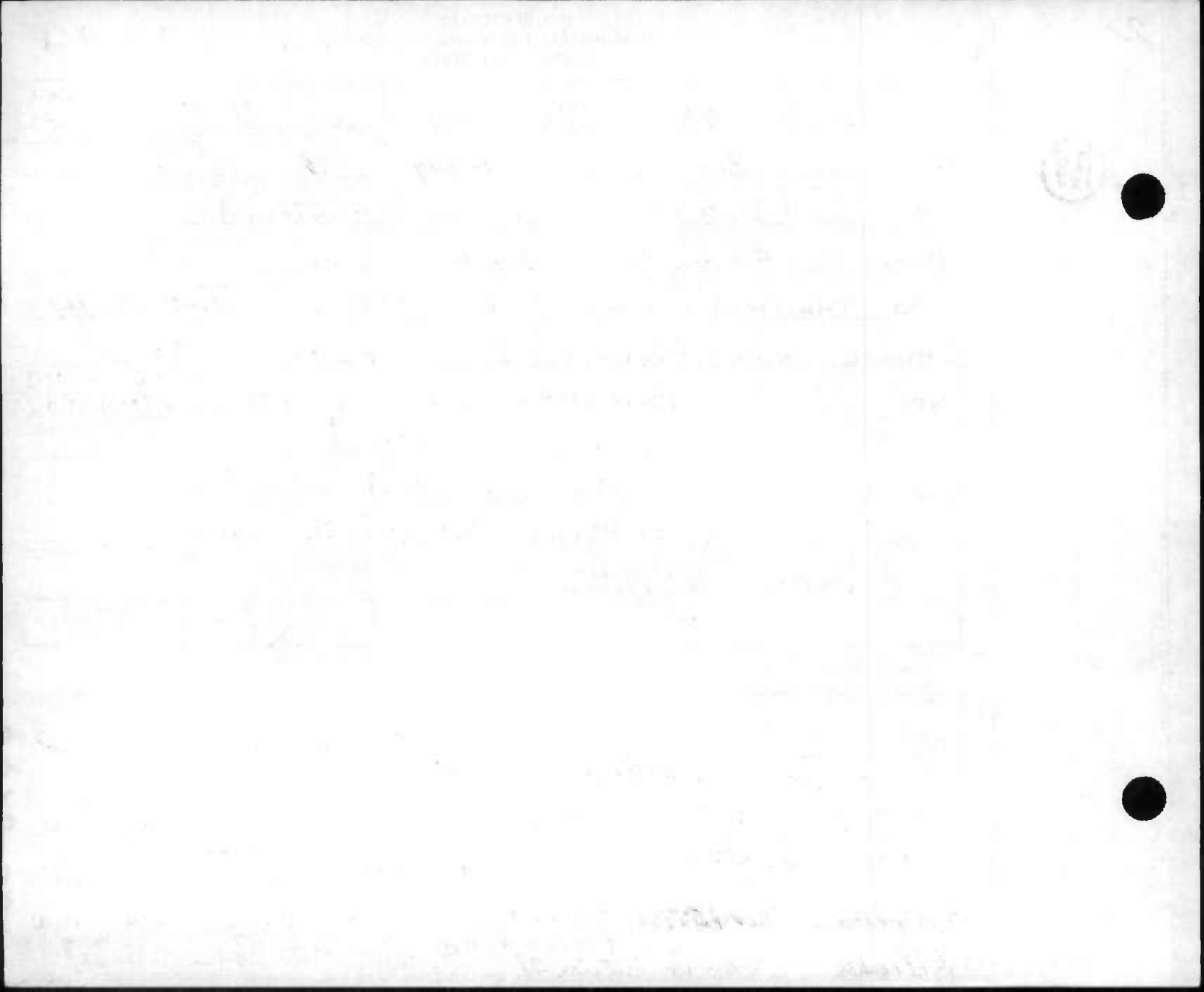
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/B2
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 4 9 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST <i>Blanche NMN Thompson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>11 10 82</i>		2b. HOUR <i>40</i> PM	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 1-1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cook</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>md</i>		13b. COUNTY <i>Hartford</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel NMN Fredericks</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen Stein</i>		16. ADDRESS <i>Frederick, md</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-20-8074</i>		17. INFORMANT <i>Helen Foreman</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertensive arteriosclerotic cardiovascular disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Mellitus</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>SEPTEMBER 1982</i> to <i>NOV. 10 1982</i> , that (I) (we) last saw the deceased alive on <i>SEPTEMBER 1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Beno Oyza</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/10/82</i>	
22d. PHYSICIAN'S NAME (TYPE) <i>BEN OYEZA</i>		22e. ADDRESS <i>1131 Baltimore Pike Bel Air md. 21014</i>					
23a. BURIAL, CREMATION, REMOVAL (IF) <i>BURIAL</i>		23b. DATE <i>NOV 15 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick Fred md</i>	
24. FUNERAL DIRECTOR <i>C. E. Hicks</i>		ADDRESS <i>242 W. Patrick ST</i>		25. DATE REC'D. BY REGISTRAR <i>NOV 18 1982</i>		25. REGISTRAR'S SIGNATURE <i>John J. Canine</i>	

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 2 9 4 9 2	
1- REGISTRAR FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) LAWRENCE WAYNE VANATTA							2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 11 13 19 82		2b. HOUR M a		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1960		6. AGE (IN YEARS) YRS. 21		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11 13 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County					
10. CITY OR TOWN OF DEATH Jarrettsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4225 St. Clair Bridge Rd.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Estimator		12b. KIND OF BUSINESS OR INDUSTRY Paint		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENTIAL ADDRESS)											
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4225 St. Clair Bridge Road			
14. FATHER'S NAME FIRST MIDDLE LAST Gerard Ronald Van Atta				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Louise Sheckells							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 220-86-2363		17. INFORMANT ADDRESS Gerard R. Van Atta, Jarrettsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9552 IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head (rifle)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 11-13- 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4225 St. Clair Bridge Rd., Jarrettsville, Harford Co., Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant Medical Examiner				DATE SIGNED 11-14-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Nov. 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Harford				23d. LOCATION CITY OR TOWN COUNTY STATE Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 16 1982				25b. REGISTRAR'S SIGNATURE 			



RECEIVED
JAN 10 1964
U.S. AIR FORCE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

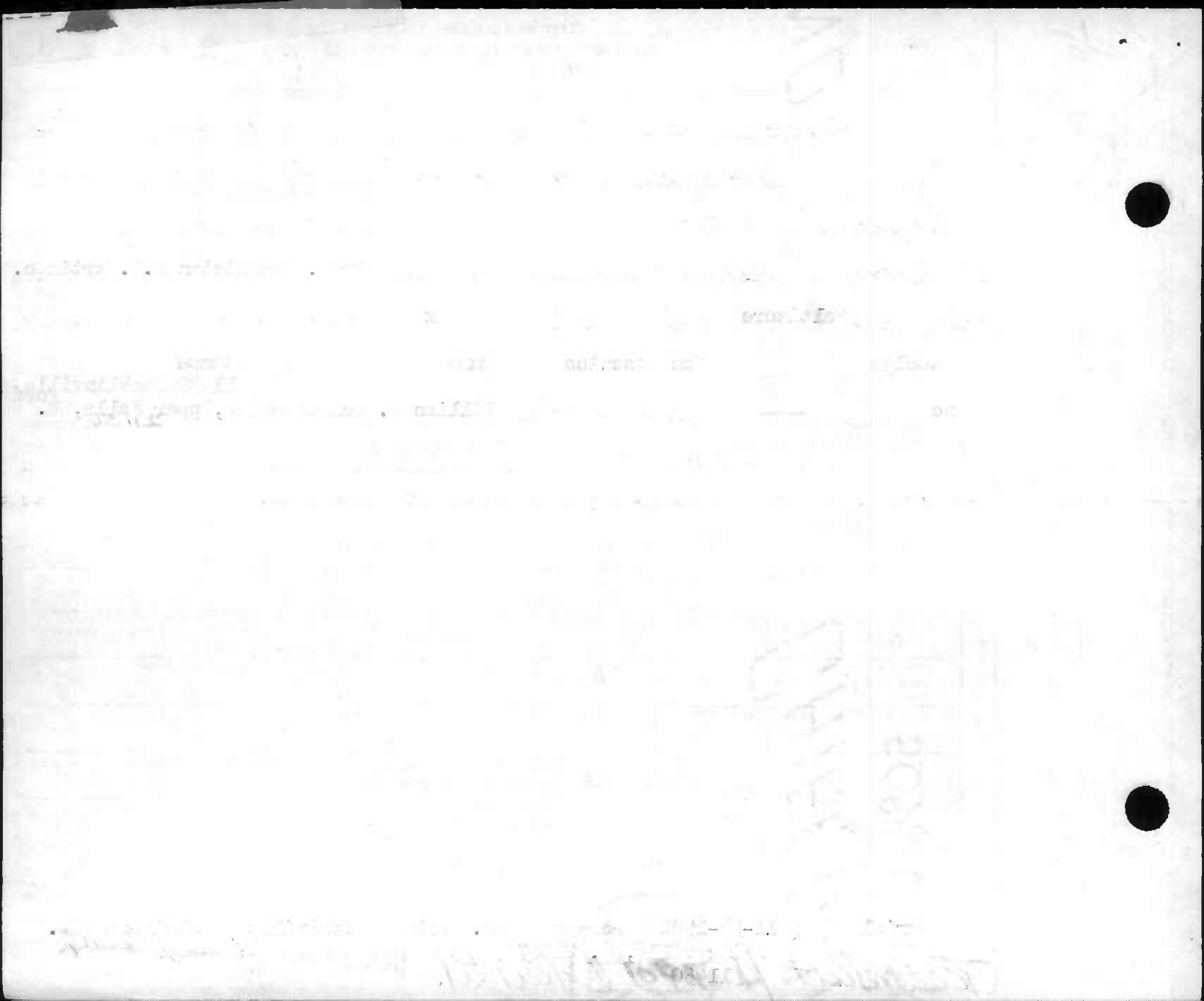
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Fritz John Von Bussenius</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 22 82</i>		2b. HOUR <i>10⁴³ AM</i>	
3. SEX <i>Male</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4 / 17 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Fallston</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Prec. Technician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>G.L. Martin Co.</i>	
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Upper Falls</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>11539 Franklinville Rd.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Adolph Von Bussenius</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Stumpe</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		16b. SOCIAL SECURITY NO. <i>217-09-8863</i>		17. INFORMANT ADDRESS <i>Lillian E. Von Bussenius, Upper Falls, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4329 IMMEDIATE CAUSE (a) BRAIN STEM COMPRESSION</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>INTRACRANIAL HEMORRHAGE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ESSENTIAL HYPERTENSION</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>N/A</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>N/A</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <i>N/A</i>		
21d. INJURY OCCURRED <i>N/A</i> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>N/A</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>N/A</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/22/82</i> , 19 <i>82</i> , to <i>11/22</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>11/22/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>R Karody</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/22/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RAMESH KARODY</i>		22e. ADDRESS <i>216, TIMBER TRAIL APTS, BEL AIR MD</i>				
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>		23b. DATE <i>11-24-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Parkville Baltimore Md.</i>		23e. DATE OF BURIAL <i>NOV 24 1982</i>				
24. FUNERAL DIRECTOR <i>James J. Karody</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 9 4

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William B. S. Ward			2a. DATE OF DEATH MONTH DAY YEAR Nov 17 1982		2b. HOUR 4:40 ^P
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAR. 25, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 92	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) STEEL WORKER	12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
13a. STATE MD.	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVREDEGRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 626 Pearl St.	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL J. WARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 084-07-7408A		17. INFORMANT NAME ADDRESS Mrs. BEULLAH F. WARD SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Cerebro-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17</u> , 19 <u>82</u> , to <u>11-17</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>11-17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Irvin L. Wachsman MD		DEGREE MD		22c. DATE SIGNED 11/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irvin L. Wachsman		22e. ADDRESS 5 Union Ave. Havre de Grace, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE Nov 20 '82	23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HAVREDEGRACE HARFORD MD	23e. DATE REC'D. BY REGISTRAR NOV 22 1982
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL F.H.P.A. HAVREDEGRACE MD.		25. REGISTRAR'S SIGNATURE John L. Cahill			

BP

DHMH - 16 50M 4/B2

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 33.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LAUREL V. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR NOV 20 1982		2b. HOUR 10³⁰ AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 26 1897		6. AGE (IN YEARS, LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Aberdeen	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 25 N. Philadelphia Boulevard		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. CITY OR TOWN Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lingham J. Onion		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice H. Whitaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-36-5007		17. INFORMANT Hazel W. Hartung, 25 N. Phila., Blvd., Aberdeen, Maryland 21001	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 4151 DUE TO, OR AS A CONSEQUENCE OF (b) FRACTURE RIGHT HIP DUE TO, OR AS A CONSEQUENCE OF (c) 7 WEEKS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 HR.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) OBSTRUCTIVE LUNG DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from SEPT 25 , 19 82 , to NOV 20 , 19 82 , that (I) lost lost saw the deceased alive on NOV 13 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.					
22b. SIGNATURE B.J. Plunkett Jr M.D.		DEGREE M.D.		22c. DATE SIGNED NOV 20, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.J. Plunkett, Jr. M.D.		22e. ADDRESS 617 W. Bel Air Ave., Aberdeen, Md. 21001			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/24/82	23c. NAME OF CEMETERY OR CREMATORY William Watters Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Coopertown Harford Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399		25a. DATE REC'D BY REGISTRAR NOV 24 1982			

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 9 6

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL GARRISON WRIGHT			20. DATE OF DEATH MONTH DAY YEAR 11 03 82			26. HOUR 145A	
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 09 29 17		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN WHITE HALL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Birmingham Garrison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Wood Calary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-18-8935		17. INFORMANT ADDRESS SELMAN WRIGHT 451/5 NORRISVILLE RD WHITE HALL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Massive intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paragotis L. Sitars		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. L. SITARS		22e. ADDRESS 1870 Belair Rd Fallt Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/1982		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Madonna Harford Md	
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz				ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR NOV 8 1982	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 4 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hazel J. Zellman			2a. DATE OF DEATH MONTH DAY YEAR November 26 1982		2b. HOUR 8:15 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2 1921		
6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			10. CITY OR TOWN OF DEATH Havre de Grace			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE AND MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 518 Craig's Corner Rd. R.D.#2				
14. FATHER'S NAME FIRST MIDDLE LAST FRED Mc Grady			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Nelson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 362-36-3434		17. INFORMANT ADDRESS Frank Zellman Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) CO PD DUE TO, OR AS A CONSEQUENCE OF (c) nausea/vomiting PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE J. Lee		DEGREE M.D.		22c. DATE SIGNED 11/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Lee		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS Anderson Medical Clinic Hdg		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 30 NOV 82		23c. NAME OF CEMETERY OR CREMATORY Deer Creek Harmony		
23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.		23e. NAME OF CEMETERY OR CREMATORY Presbytertain Church Md				
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME, PA, HAVRE DE GRACE, MD.		25a. DATE REC'D. BY REGISTRAR DEC 1 1982		25b. REGISTRAR'S SIGNATURE John J. Connel		

Handwritten notes and signatures on lined paper, including a large circular stamp in the center.

